Meeting Date	**28th November 2018**	**Agenda Item**	**3iii**
Report Title	**Integrated Performance Report**		
Report Author	Hannah Roan, Performance and Contracting Manager		
Report Sponsor	Darren Griffiths, Associate Director of Performance		
Presented by	Darren Griffiths, Associate Director of Performance Leads		
Freedom of Information	Open		
Purpose of the Report	The purpose of this report is to provide an update on the current performance of the Health Board at the end of the most recent reporting window in delivering key performance measures outlined in the 2018/19 NHS Wales Delivery Framework.		
Key Issues	This Integrated Performance Report provides an overview of how the Health Board is performing against the National Delivery measures and key local quality and safety measures. Actions are listed where performance is not compliant with national or local targets as well as highlighting both short term and long terms risks to delivery. The layout of the report has been revised this month to include a number of additional pages on the unscheduled care system, the planned care system and theatre efficiencies in order to meet the requirements of the committee. A suite of performance report cards have also been included in this report as a detailed summary of end of quarter two performance. The report cards can be found in section nine of this report. The NHS Delivery Framework contains a number of qualitative measures that are reported via self-assessment templates. Internal Audit has recommended that the committee should have sight of the submissions, therefore copies of the reporting templates submitted to Welsh Government in October 2018 are included in Section 10 of this report.		
Specific Action Required	**Information**	**Discussion**	**Assurance**	**Approval**
	✓		✓	

Recommendations	Members are asked to: • note current Health Board performance against key measures and targets and the actions being taken to improve performance. • endorse submission of the self-assessment templates to Welsh Government

Governance and Assurance

Link to corporate objectives *(please ✓)*	Promoting and enabling healthier communities	Delivering excellent patient outcomes, experience and access	Demonstrating value and sustainability	Securing a fully engaged skilled workforce	Embedding effective governance and partnerships
	✓	✓	✓	✓	✓

Link to Health and Care Standards *(please ✓)*	Staying Healthy	Safe Care	Effective Care	Dignified Care	Timely Care	Individual Care	Staff and Resources
	✓	✓	✓	✓	✓	✓	✓

Quality, Safety and Patient Experience

The performance report outlines performance over the domains of quality and safety and patient experience, and outlines areas and actions for improvement.

Quality, safety and patient experience are central principles underpinning the National Delivery Framework and this report is aligned to the domains within that framework.

There are no directly related Equality and Diversity implications as a result of this report.

Financial Implications

At this stage in the financial year there are no direct impacts on the Health Board's financial bottom line resulting from the performance reported herein except for planned care.

Planned Care additional capacity is funded by £8.3m to support delivery of target levels. Failure to deliver these target levels will result in claw back of funds by Welsh Government. The decision on whether to apply clawback or not, it is understood, will be made at the end of quarter 3.

The achievement of releasable efficiency and productivity targets could deliver savings to support the financial position.

Legal Implications (including equality and diversity assessment)

A number of indicators monitor progress in relation to legislation, such as the Mental Health Measure.

Staffing Implications
A number of indicators monitor progress in relation to Workforce, such as Sickness and Personal Development Review rates. Specific issues relating to staffing are also addressed individually in this report.
Long Term Implications (including the impact of the Well-being of Future Generations (Wales) Act 2015)
The '5 Ways of Working' are demonstrated in the report as follows: Long term – Actions within this report are both long and short term in order to balance the immediate service issues with long term objectives. In addition, profiles have been included for the Targeted Intervention Priorities for 2018/19 which provides focus on the expected delivery for every month as well as the year end position in March 2019. Prevention – the NHS Wales Delivery framework provides a measureable mechanism to evidence how the NHS is positively influencing the health and well-being of the citizens of Wales with a particular focus upon maximising people's physical and mental well-being. Integration – this integrated performance report brings together key performance measures across the seven domains of the NHS Wales Delivery Framework, which identify the priority areas that patients, clinicians and stakeholders wanted the NHS to be measured against. The framework covers a wide spectrum of measures that are aligned with the Well-being of Future Generations (Wales) Act 2015. Collaboration – in order to manage performance, the Corporate Functions within the Health Board liaise with leads from the Delivery Units as well as key individuals from partner organisations including the Local Authorities, Welsh Ambulance Services Trust, Public Health Wales and external Health Boards. Involvement – Corporate and Delivery Unit leads are key in identifying performance issues and identifying actions to take forward.

Report History	The last iteration of the Integrated Performance Report was presented to the Performance & Finance Committee and Quality & Safety Committee in October 2018.
Appendices	None

Summary of performance against national and local measures

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9. QUARTERLY PERFORMANCE REPORT CARDS

10. NHS WALES SELF ASSESSMENT TEMPLATES

11. LIST OF ABBREVIATIONS

1. OVERVIEW

The following summarises the key successes, along with the priorities, risks and threats to achievement of the quality, access and workforce standards.

Successes	Priorities
• The percentage of patients waiting under 26 weeks from referral to treatment continues to be the highest since June 2013. • Therapy waiting times continue to be maintained at (or below) 14 weeks. • Sustained nil position in October 2018 for Endoscopy patients waiting over 8 weeks. • Stroke performance is improving and internal profiles achieved for admission within 4 hours, CT scan within 1 hour and consultant assessment within 24 hours. Morriston made the biggest contribution towards the 4 hour target by achieving 71.7% in October 2018. This is the highest compliance recorded for Morriston as a result of the front door pilot. • Internal profiles achieved for number of C. difficile, Staph. Aureus Bacteraemia and E.Coli cases in October 2018	• Conclusion of the winter assurance planning arrangements and implementation of quarter 3 unscheduled care improvements plans. • Roll-out of 2018/19 winter flu immunisation programme. • Development of deliverable and measurable Unit plans as the basis for the Health Board's 2019/22 Integrated Medium Term Plan (IMTP). • Maintaining and enhancing resilience of core theatre capacity in orthopaedics in particular and securing additional clinics in order to continue to maintain excellent OP wait position. • Sustain cancer performance by reviewing practice around authorisation of Annual Leave of medical staff especially over the Christmas period. • Month on month increase the number of staff who have been competence assessed for Aseptic Non Touch Technique (ANTT). • Act on the results of the staff survey and actively encourage staff from hotspot areas to attend the ACAS workshops.
Opportunities	**Risks & Threats**
• Launch of a new General Dental Practitioner fellowship scheme with the aim of improving the suitability of dental service • Utilising outsourcing arrangements in order to continue to reduce the number of patients waiting over 36 weeks for treatment. • Staff workshops to be held in November to enable staff to help shape ABMU's future by using the results of the staff survey and the overall direction of the organisation to identify ways to enhance staff and patient experience. • Quality Improvement methodology being utilised in areas such as A&E and infection control to drive forward improvement projects. Dedicated Quality Improvement Clinical Leads have also been appointed. • Funding of paramedic posts in Out of Hours service which will enable 24/7 paramedic cover.	• Increasing pressure on the unscheduled care and patient flow in the winter months which could impact on the Health Board's ability to maintain core elective capacity. • Some theatre areas have vacancies and sickness pressures and any further loss of staff could pressure elective delivery. • Use of pre-emptive beds on acute sites increases the risk of infection outbreaks. • Anticipated impact of No Deal Brexit could include reduced availability of medical equipment, spares and consumables. • Recruitment market for substantive nursing and medical vacancies. • Continued challenge to reduce sickness rates across the Health Board. • Hospital and social care flow constraints which impact upon the Emergency Department's ability to receive timely ambulance handovers.

2. TARGETED INTERVENTION PRIORITY MEASURES SUMMARY (HEALTH BOARD LEVEL) – October 2018

			Quarter 1			Quarter 2			Quarter 3			Quarter 4			All-Wales benchmark position
			Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Sep-18
Unscheduled Care	4 hour A&E waits	Actual	75.6%	78.9%	81.0%	79.9%	77.9%	77.5%	78.0%						6th
		Profile	*83%*	*83%*	*83%*	*88%*	*88%*	*88%*	*89%*	*90%*	*90%*	*90%*	*90%*	*90%*	
	12 hour A&E waits	Actual	737	624	476	590	511	588	680						5th
		Profile	*323*	*194*	*190*	*229*	*227*	*180*	*255*	*315*	*288*	*283*	*196*	*179*	
	1 hour ambulance handover	Actual	526	452	351	443	420	526	590						5th**
		Profile	*256*	*126*	*152*	*159*	*229*	*149*	*223*	*262*	*304*	*262*	*183*	*139*	
Stroke	Direct admission within 4 hours	Actual	34.9%	37.5%	40.0%	37.5%	29.3%	53.8%	56.0%						2nd** *(Oct-18)*
		Profile	*45%*	*45%*	*45%*	*50%*	*50%*	*50%*	*50%*	*50%*	*50%*	*65%*	*65%*	*65%*	
	CT scan within 1 hour	Actual	41.4%	43.3%	51.3%	40.3%	40.5%	47.5%	52.7%						4th** *(Oct-18)*
		Profile	*40%*	*40%*	*40%*	*45%*	*45%*	*45%*	*45%*	*45%*	*45%*	*50%*	*50%*	*50%*	
	Assessed by Stroke Specialist within 24 hours	Actual	83.9%	93.3%	88.2%	80.6%	91.1%	68.8%	82.8%						4th** *(Oct-18)*
		Profile	*75%*	*75%*	*75%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*85%*	*85%*	*85%*	
	Thrombolysis door to needle within 45 minutes	Actual	0.0%	11.1%	37.5%	21.4%	0.0%	11.1%	18.2%						4th** *(Oct-18)*
		Profile	*20%*	*25%*	*25%*	*30%*	*30%*	*30%*	*35%*	*35%*	*35%*	*40%*	*40%*	*40%*	
Planned care	Outpatients waiting more than 26 weeks	Actual	*166*	*120*	*55*	*30*	*105*	*89*	*65*						2nd *(Aug-18)*
		Profile	*249*	*200*	*150*	*100*	*50*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	
	Treatment waits over 36 weeks	Actual	*3,398*	*3,349*	*3,319*	*3,383*	*3,497*	*3,381*	*3,370*						6th *(Aug-18)*
		Profile	*3,457*	*3,356*	*3,325*	*3,284*	*3,287*	*3,067*	*2,773*	*2,709*	*3,045*	*2,854*	*2,622*	*2,664*	
	Diagnostic waits over 8 weeks	Actual	*702*	*790*	*915*	*740*	*811*	*762*	*735*						5th *(Aug-18)*
		Profile	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	
	Therapy waits over 14 weeks	Actual	*0*	*1*	*0*	*0*	*0*	*0*	*0*						Joint 1st *(Aug-18)*
		Profile	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	
Cancer	NUSC patients starting treatment in 31 days	Actual	92%	90%	95%	99%	97%	96%	94%						2nd** *(Aug-18)*
		Profile	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*	
	USC patients starting treatment in 62 days	Actual	77%	89%	83%	92%	94%	83%	83%						1st** *(Aug-18)*
		Profile	*83%*	*85%*	*89%*	*90%*	*91%*	*91%*	*92%*	*92%*	*91%*	*92%*	*92%*	*93%*	
Healthcare Acquired Infections	Number of healthcare acquired C.difficile cases	Actual	26	18	15	29	15	9	19						6th
		Profile	*21*	*18*	*26*	*20*	*22*	*20*	*20*	*24*	*13*	*19*	*15*	*21*	
	Number of healthcare acquired S.Aureus Bacteraemia cases	Actual	14	21	19	17	20	10	12						6th
		Profile	*13*	*18*	*13*	*18*	*11*	*13*	*13*	*15*	*21*	*13*	*19*	*15*	
	Number of healthcare acquired E.Coli Bacteraemia cases	Actual	42	43	41	51	46	49	41						6th
		Profile	*45*	*39*	*40*	*45*	*42*	*45*	*44*	*37*	*41*	*45*	*39*	*42*	

**RAG status derived from performance against trajectory*

*** All-Wales benchmark highlights ABMU's positon in comparison with the other seven Health Boards however some measures are only applicable to six of the seven Health Board as Powys tHB has been excluded*

3. INTEGRATED PERFORMANCE DASHBOARD

The following dashboard provides an overview of the Health Board's performance against all NHS Wales Delivery Framework measures and key local measures.

STAYING HEALTHY- People in Wales are well informed and supported to manage their own physical and mental health

Sub Domain	Measure	Report Period	Current Performance	National Target	Annual Plan/ Local Profile	Profile Status	Welsh Average	Performance Trend	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18
Childhood Immunisation & Heath Visiting	% children who received 3 doses of the hexavalent '6 in 1' vaccine by age 1	Q2 18/19	96%	95%			95.3%													96%	
	% of children who received 2 doses of the MMR vaccine by age 5	Q2 18/19	90%	95%	92%	✗	89.5%				91%			89%			91%			90%	
	% 10 day old children who have accessed the 10-14 days health visitor contact component of the Healthy Child Wales Programme	Q4 17/18	77%	4 quarter ↑ trend			87.4%				54%			77%							
Influenza	% uptake of influenza among 65 year olds and over	2017/18	68%	75%	70%	✗	69%		33%	66%	66%	68%	68%	68%							43%
	% uptake of influenza among under 65s in risk groups	2017/18		55%	65%	✗	49%		18%	43%	43%	46%	47%	47%							25%
	% uptake of influenza among pregnant women	2017/18	93%	75%		✓	73%							93%							
	% uptake of influenza among children 2 to 3 years old	2017/18	49%		40%	✓			6.6%	44.9%	44.9%	48.4%	49.1%	49%							20%
	% uptake of influenza among healthcare workers	Oct-18	43%	50%					49%	54%	55%	57%	58%	58%							43%
Smoking	% of pregnant women who gave up smoking during pregnancy (by 36- 38 weeks of pregnancy)	2017/18	4.4%	Annual ↑			27.1%		2017/18= 4.4%												
	% of adult smokers who make a quit attempt via smoking cessation services	Aug-18	1.1%	5% annual target	1.4%	✗			1.4%	1.6%	1.7%	2.1%	2.3%	2.6%	0.2%	0.5%	0.7%	0.9%	1.1%		
	% of those smokers who are co-validated as quit at 4 weeks	Q1 18/19	61.5%	40% annual target	40.0%	✓	42.6%				53%			55%			62%				
Learning Disabilities	% people with learning disabilities with an annual health check			75%											*Awaiting publication of 2018/19 data.*						
Primary Care	% people (aged 16+) who found it difficult to make a convenient GP appointment	2017/18	48.0%	Annual ↓			42.2%		2017/18= 48%												

SAFE CARE- People in Wales are protected from harm and supported to protect themselves from known harm

Sub Domain	Measure	Report Period	Current Performance	National Target	Annual Plan/ Local Profile	Profile Status	Welsh Average	Performance Trend	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18
Prescribing	Total antibacterial items per 1,000 STAR-PUs	Q1 18/19	307	4 quarter ↓			340				346			364			307				
	Fluroquinolone, cephalosoporin, clindamycin and co-amoxiclav items as a % of total antibacterial items prescribed	Q1 18/19	10%	4 quarter ↓			7.6%				9%			9%			10%				
	NSAID average daily quantity per 1,000 STAR-Pus	Q1 18/19	1,517	4 quarter ↓			1,405				1,541			1,496			1,517				
	Number of administration, dispensing and prescribing medication errors reported as serious incidents	Aug-18	0	12 month ↓	0	✓	1		0	0	0	0	0	0	0	0	0	0	0	0	
Antimicrobial Audits	% indication for antibiotic documented on medication chart	Sep-18	91%		*95%*	✗				*91%*		*89%*		*87%*				*87%*		*91%*	
	% stop or review date documented on medication chart	Sep-18	54%		*95%*	✗				*52%*		*59%*		*61%*				*61%*		*54%*	
	% of antibiotics prescribed on stickers	Sep-18	73%		*95%*	✗				*91%*		*79%*		*70%*				*77%*		*73%*	
	% appropriate antibiotic prescriptions choice	Sep-18	97%		*95%*	✓				*94%*		*92%*		*94%*				*96%*		*97%*	
	% of patients receiving antibiotics for >7 days	Sep-18	15%		*20%*	✓				*11%*		*9%*		*13%*				*8%*		*15%*	
	% of patients receiving surgical prophylaxis for > 24 hours	Sep-18	8%		*20%*	✓				*57%*		*58%*		*58%*				*25%*		*8%*	
	% of patients receiving IV antibiotics > 72 hours	Sep-18	49%		*30%*	✗				*36%*		*43%*		*39%*				*41%*		*49%*	
infection control	Cumulative cases of E.coli bacteraemias per 100k pop	Oct-18	100.5	<67			83.28								96.6	96.1	96.2	98.9	99.6	102.1	100.5
	Number of E.Coli bacteraemia cases (Hospital)	*Oct-18*	*17*		*14*	✗	76		*15*	*17*	*17*	*18*	*4*	*10*	*10*	*15*	*10*	*20*	*16*	*15*	*17*
	Number of E.Coli bacteraemia cases (Community)		*24*		*30*	✓	125		*37*	*22*	*26*	*29*	*14*	*30*	*32*	*28*	*31*	*31*	*30*	*34*	*24*
	Total number of E.Coli bacteraemia cases		*41*		44	✓	201		52	39	43	47	18	40	42	43	41	51	46	49	41
	Cumulative cases of S.aureus bacteraemias per 100k pop	Oct-18	*35.8*	<20			29.09								32.2	39.6	40.9	37.3	41.0	37.7	35.8
	Number of S.aureus bacteraemias cases (Hospital)	*Oct-18*	*7*		*6*	✗	45		*6*	*5*	*13*	*8*	*8*	*10*	*6*	*8*	*7*	*8*	*9*	*7*	*7*
	Number of S.aureus bacteraemias cases (Community)		*5*		*7*	✓	36		*8*	*12*	*12*	*6*	*13*	*5*	*8*	*13*	*12*	*9*	*11*	*3*	*5*
	Total number of S.aureus bacteraemias cases		*12*		13	✓	81		14	17	25	14	21	15	14	21	19	17	20	10	12
	Cumulative cases of C.difficile cases per 100k pop	Oct-18	*42.2*	<26			29.64								59.8	49.7	44.7	50.3	46.4	42.2	42.2
	Number of C.difficile cases (Hospital)	*Oct-18*	*15*		*17*	✓	32		*20*	*24*	*10*	*16*	*14*	*19*	*20*	*13*	*10*	*24*	*8*	*5*	*15*
	Number of C.difficile cases (Community)		*4*		*3*	✗	29		*4*	*4*	*4*	*6*	*4*	*8*	*6*	*5*	*5*	*5*	*7*	*4*	*4*
	Total number of C.difficile cases		*19*		20	✓	61		24	28	14	22	18	27	26	18	15	29	15	9	19
	Hand Hygiene Audits- compliance with WHO 5 moments	Oct-18	98%		95%	✓			96%	94%	96%	95%	95%	94%	95%	96%	95%	96%	97%	98%	98%
Incidents & Risks	Number of Patient Safety Solutions Wales Alerts and Notices that were not assured within the agreed timescale	Q1 17/18	2	0			2			2		0					2				
	Of the serious incidents due for assurance, the % which were assured within the agreed timescales	Oct-18	56%	90%	80%	✗	27.2%		83%	86%	89%	85%	92%	92%	79%	85%	85%	81%	87%	86%	56%
	Number of new Never Events	Oct-18	0	0	0	✓	4		0	1	1	1	2	4	0	0	0	0	0	0	0
	Number of risks with a score greater than 20	Oct-18	66		12 month ↓	✗			64	59	60	78	57	57	58	57	60	67	77	73	66
	Number of Safeguarding Adult referrals relating to Health Board staff/ services	Oct-18	13		12 month ↓	✓			11	6	11	12	8	10	8	12	10	22	14	7	13
	Number of Safeguarding Children Incidents	Oct-18	0		0	✗			10	5	2	8	5	12	5	11	5	12	14	3	0
Pressure Ulcers	Total number of pressure ulcers acquired in hospital	Oct-18	47		12 month ↓	✗			47	43	49	51	37	46	48	47	39	56	45	53	47
	Total number of pressure ulcers acquired in hospital per 100k admissions	Oct-18	489		12 month ↓	✗			525	495	572	602	497	553	581	515	463	650	517	619	489
	Number of grade 3+ pressure ulcers acquired in hospital	Oct-18	26		12 month ↓	✗			18	19	19	22	13	26	17	9	14	21	12	21	26
	Number of grade 3+ pressure ulcers acquired in hospital per 100k admissions	Oct-18	270		12 month ↓	✓			205	219	231	255	162	306	202	99	166	244	144	226	270
	Total Number of pressure ulcers developed in the community	Oct-18	60		12 month ↓	✗			27	62	69	52	57	69	67	80	81	68	88	71	60
	Number of grade 3+ pressure ulcers developed in the community	Oct-18	26		12 month ↓	✗			12	16	19	9	23	20	24	24	27	20	29	22	26
	Number of grade 3+ pressure ulcers reported as serious incidents	Sep-18	8	12 month ↓	10	✗	104		10	5	6	18	6	13	12	13	21	5	17	8	
Inpatient Falls	Number of Inpatient Falls	Oct-18	293		12 month ↓	✓			326	347	318	344	309	357	333	357	326	300	290	328	293
	Number of Inpatient Falls reported as serious incidents	Sep-18	3	12 month ↓	2	✗	32		4	2	3	8	5	2	2	4	3	5	1	3	
Self Harm	Rate of hospital admissions with any mention of intentional self-harm of children and young people (aged 10-24 years)	2017/18	3.14	Annual ↓			4.00		2017/18= 3.14												
Mortality	Amenable mortality per 100k of the European standardised population	2016	142.9	Annual ↓			140.6		2016= 142.9												
HAT	Number of potentially preventable hospital acquired thromboses (HAT)	Q2 17/18	2	4 quarter ↓			17														
Sepsis	% in-patients with a positive sepsis screening who have received all elements of the 'Sepsis Six' 1st hour care bundle within 1 hour of positive screening	Aug-18	18%	12 month ↑			68%										16%			18%	
	% patients who presented at ED with a positive sepsis screening who have received all elements of the 'Sepsis Six' 1 hour care bundle within 1 hour of positive screening	Aug-18	36%	12 month ↑			59%										34%			36%	

EFFECTIVE CARE- People in Wales receive the right care and support as locally as possible and are enabled to contribute to making that acre successful																							
Sub Domain	**Measure**	**Report Period**	**Current Performance**	**National Target**	**Annual Plan/ Local Profile**	**Profile Status**	**Welsh Average**	**Performance Trend**	**Oct-17**	**Nov-17**	**Dec-17**	**Jan-18**	**Feb-18**	**Mar-18**	**Apr-18**	**May-18**	**Jun-18**	**Jul-18**	**Aug-18**	**Sep-18**	**Oct-18**
DTOCs	Number of mental health HB DToCs	Oct-18	28		27	✗			30	30	31	29	21	25	28	22	30	27	30	29	28
	Number of mental health HB DToCS (12 month rolling)	Oct-18	330	10% ↓			4,233		305	319	331	340	334	333	335	331	334	337	338	332	330
	Number of non-mental health HB DToCs	Oct-18	84		51	✗			59	68	55	41	53	44	34	64	75	74	85	69	84
	Number of non-mental health HB DToCs (12 month rolling)	Oct-18	746	5% ↓			930		621	628	623	615	625	624	613	625	657	689	721	721	746
Mortality	% of universal mortality reviews (UMRs) undertaken within 28 days of a death	Oct-18	93%	95%	96%	✗	67.0%		91%	95%	93%	91%	91%	91%	95%	95%	93%	95%	90%	96%	93.0%
	Stage 2 mortality reviews required	Oct-18	16						10	24	19	17	14	18	23	14	16	12	18	18	16
	% stage 2 mortality reviews completed	Aug-18	0		100%				60.0%	62.5%	54.6%	64.7%	71.4%	33.3%	87.0%	64.3%	62.5%	50.0%	44.0%		
	Crude hospital mortality rate (74 years of age or less)	Sep-18	0.78%	12 month ↓			0.73%		0.81%	0.81%	0.80%	0.80%	0.80%	0.81%	0.81%	0.81%	0.80%	0.79%	0.78%	0.78%	
NEWS	% patients with completed NEWS scores & appropriate responses actioned	Oct-18	97.5%		100%	✗			99.7%	94.4%	98.6%	97.5%	98.0%	96.9%	96.6%	98.3%	98.0%	99.2%	99.2%	97.9%	97.5%
Info Gov	% compliance of level 1 Information Governance (Wales training)	Sep-18	77%	85%					57%	59%	59%	60%	60%	61%	62%	64%	66%	71%	74%	77%	
Coding	% of episodes clinically coded within 1 month of discharge	Sep-18	96%	95%	95%	✓	86.4%		95%	89%	95%	93%	91%	93%	94%	93%	94%	95%	93%	96%	
	% of clinical coding accuracy attained in the NWIS national clinical coding accuracy audit programme	2017/18	93%	Annual ↑			91.7%		2017/18= 93%												
E-TOC	% of completed discharge summaries	Oct-18	67%		100%	✗			66.0%	66.0%	67.0%	62.0%	64.0%	65.0%	68.0%	64.0%	60.0%	59.0%	62.0%	61.0%	67.0%
Treatment Fund	All new medicines must be made available no later than 2 months after NICE and AWMSG appraisals	Q1 18/19	100%	100%	100%	✓	98%				100%			100%			100%				
Research	Number of Health and Care Research Wales clinical research portfolio studies	Q1 18/19	58	10% annual ↑	26	✓					85			96			58				
	Number of Health and Care Research Wales commercially sponsored studies	Q1 18/19	15	5% annual ↑	12	✓					38			41			15				
	Number of patients recruited in Health and Care Research Wales clinical research portfolio studies	Q1 18/19	721	10% annual ↑	607	✓					1492			2,206			721				
	Number of patients recruited in Health and Care Research Wales commercially sponsored studies	Q1 18/19	32	5% annual ↑	105	✗					223			294			32				

DIGNIFIED CARE- People in Wales are treated with dignity and respect and treat others the same																							
Sub Domain	**Measure**	**Report Period**	**Current Performance**	**National Target**	**Annual Plan/ Local Profile**	**Profile Status**	**Welsh Average**	**Performance Trend**	**Oct-17**	**Nov-17**	**Dec-17**	**Jan-18**	**Feb-18**	**Mar-18**	**Apr-18**	**May-18**	**Jun-18**	**Jul-18**	**Aug-18**	**Sep-18**	**Oct-18**
Patient Experience	Average rating given by the public (age 16+) for the overall satisfaction with health services in Wales	2016/17	5.97	Annual ↑			6.19		2016/17= 5.97. Awaiting publication of 2017/18 data.												
	Number of new formal complaints received	Oct-18	140		12 month ↓ trend	✗			129	111	97	122	91	115	119	119	90	126	126	114	140
	% concerns that had final reply (Reg 24)/interim reply (Reg 26) within 30 working days of concern received	Aug-18	81%	75%	78%	✓	52.4%		78%	73%	80%	80%	61%	71%	80%	83%	80%	81%	81%		
	% of acknowledgements sent within 2 working days	Oct-18	100%		100%	✓			100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	% of adults (age 16+) who reported that they were very satisfied or fairly satisfied about the care that they received at their GP/family doctor	2017/18	83.4%	Annual ↑			85.5%		2017/18= 83.4%												
	% of adults (age 16+) who reported that they were very satisfied or fairly satisfied about the care that they received at an NHS hospital	2017/18	89.0%	Annual ↑			89.8%		2017/18= 89.0%												
	Number of procedures postponed either on the day or the day before for specified non-clinical reasons	Aug-18	3,544	> 5% annual ↓			15,587									4,187		3,528	3,544		
Dementia	% of patients aged>=75 with an Anticholinergic Effect on Condition of >=3 for items on active repeat	Q1 18/19	8.0%	4 quarter ↓			7.3%				8.2%			8.0%			8.0%				
	% of people with dementia in Wales age 65 years or over who are diagnosed (registered on a GP QOF register)	2017/18	58.8%	Annual ↑			53.1%		2017/18= 57.6%												
	% GP practices that completed MH DES in dementia care or other direct training	2016/17	16.7%	Annual ↑			21.6%		2016/17= 16.7%. Awaiting publication of 2017/18 data.												

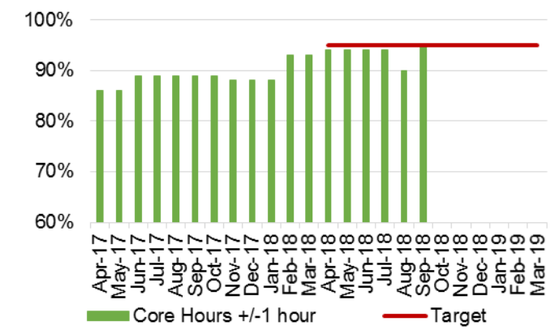
TIMELY CARE- People in Wales have timely access to services based on clinical need and are actively involved in decisions about their care																							
Sub Domain	**Measure**	**Report Period**	**Current Performance**	**National Target**	**Annual Plan/ Local Profile**	**Profile Status**	**Welsh Average**	**Performance Trend**	**Oct-17**	**Nov-17**	**Dec-17**	**Jan-18**	**Feb-18**	**Mar-18**	**Apr-18**	**May-18**	**Jun-18**	**Jul-18**	**Aug-18**	**Sep-18**	**Oct-18**
Primary Care	% of GP practices open during daily core hours or within 1 hour of daily core hours	Sep-18	95%	Annual ↑	95%	✗	87%		89%	88%	88%	88%	93%	93%	94%	94%	94%	94%	90%	95%	
	% of GP practices offering daily appointments between 17:00 and 18:30 hours	Sep-18	88%	Annual ↑	95%	✗	84%		84%	84%	84%	84%	82%	81%	82%	82%	82%	84%	78%	88%	
	% of population regularly accessing NHS primary dental care	Jun-18	62.5%	4 quarter ↑			55%				62.3%			62.6%			62.5%				
Out of Hours/ Unscheduled Care	% of P1 calls that were logged and patients started their definitive assessment within 20 minutes of the initial calls being answered	Aug-18	89.2%	12 month ↑					85%	85%	82%	80%	77%	78%	83%	85%	86%	85%	89%		
	% of patients prioritised as P1 and seen (either in PCC or home visit) within 60 minutes following their clinical assessment/face to face triage	Aug-18	100.0%	12 month ↑					56%	100%	75%	83%	33%	67%	50%	60%	67%	33%	100%		
	% of emergency responses to red calls arriving within (up to and including) 8 minutes	Oct-18	75%	65%	65%	✓	73.9%		73%	73%	69%	66%	69%	67%	78%	77%	78%	77%	79%	78%	75%
	Number of ambulance handovers over one hour	Oct-18	590	0	137	✗	2,132		617	727	903	1,030	805	1,006	526	452	351	443	420	526	590
	% of patients who spend less than 4 hours in all major and minor emergency care (i.e. A&E) facilities from arrival until admission, transfer or discharge	Oct-18	78.0%	95%	89%	✗	80%		79.1%	75.8%	73.4%	76.1%	73.8%	71.4%	75.6%	78.9%	81.0%	79.9%	77.9%	77.5%	78.0%
	Number of patients who spend 12 hours or more in all hospital major and minor care facilities from arrival until admission, transfer or discharge	Oct-18	680	0	255	✗	3,085		706	875	871	924	957	1,051	737	624	476	590	511	588	680
	% of survival within 30 days of emergency admission for a hip fracture	Jul-18	70.8%	12 month ↑			77.4%		80.2%	80.8%	74.3%	84.5%	85.9%	84.9%	72.4%	85.0%	78.3%	70.8%			
Stroke	Direct admission to Acute Stroke Unit (<4 hrs)	Oct-18	56%	58.7%	50%	✓	80.8%		44%	33%	24%	29%	22%	32%	35%	38%	40%	38%	29%	54%	56%
	CT Scan (<1 hrs)	Oct-18	53%	52.80%	45%	✓	52.0%		36%	38%	36%	35%	44%	36%	41%	43%	51%	40%	41%	48%	53%
	Assessed by a Stroke Specialist Consultant Physician (< 24 hrs)	Oct-18	83%	84.5%	80%	✓	85.1%		89%	80%	72%	81%	73%	73%	84%	93%	88%	81%	91%	69%	83%
	Thrombolysis door to needle <= 45 mins	Oct-18	18%	12 month ↑	35%	✗	23.6%		17%	22%	10%	0%	8%	6%	0%	11%	38%	21%	0%	11%	18%
Planned Care	% of patients waiting < 26 weeks for treatment	Oct-18	89.1%	95%	89.7%	✗	87.6%		86.9%	86.2%	85.3%	86.2%	87.5%	87.8%	87.8%	88.1%	88.7%	89.3%	89.1%	89.1%	89.1%
	Number of patients waiting > 26 weeks for outpatient appointment	Oct-18	65	-	0	✗	18,790		1,438	1,524	1,679	1,111	732	292	166	120	55	30	105	89	65
	Number of patients waiting > 36 weeks for treatment	Oct-18	3,370	0	1,784	✗	15,622		4,463	4,561	4,714	4,609	4,111	3,363	3,398	3,349	3,319	3,383	3,497	3,381	3,370
	Number of patients waiting > 8 weeks for a specified diagnostics	Oct-18	735	0	0	✗	4,817		997	1,037	1,260	1,179	925	670	702	790	915	740	811	762	735
	Number of patients waiting > 14 weeks for a specified therapy	Oct-18	0	0	0	✓	302		111	111	95	32	3	0	0	1	0	0	0	0	0
	Number of patients waiting for an outpatient follow-up (booked and not booked) who are delayed past their agreed target date (all specialties)	Oct-18	63,538		52,811	✗			59,828	59,584	62,797	62,492	64,316	66,271	66,526	65,287	63,776	64,318	65,407	66,269	63,538
	Number of patients waiting for an outpatient follow-up (booked and not booked) who are delayed past their agreed target date (planned care specs only)	Oct-18	22,553	12 month ↓			192,301		21,075	20,648	22,364	22,414	23,198	24,475	24,628	24,288	24,469	24,954	24,813	24,200	22,553
Cancer	% of patients newly diagnosed with cancer, not via the urgent route, that started definitive treatment within (up to and including) 31 days of diagnosis (regardless of referral route)	Oct-18	94%	98%	98%	✗	96.4%		95%	99%	94%	91%	94%	93%	92%	90%	95%	99%	97%	96%	94%
	% of patients newly diagnosed with cancer, via the urgent suspected cancer route, that started definitive treatment within (up to and including) 62 days receipt of referral	Oct-18	83%	95%	92%	✗	87.0%		85%	89%	82%	79%	83%	88%	77%	89%	83%	92%	94%	83%	83%
Mental Health	% of mental health assessments undertaken within (up to and including) 28 days from the date of receipt of referral	Sep-18	76%	80%	80%	✗	84.0%		65%	65%	65%	67%	74%	70%	84%	86%	82%	84%	80%	76%	
	% of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS	Sep-18	89%	80%	80%	✓	82.4%		97%	79%	70%	75%	89%	86%	79%	81%	80%	79%	90%	89%	
	% of qualifying patients (compulsory & informal/voluntary) who had their first contact with an IMHA within 5 working days of the request for an IMHA	Sep-18	100%	100%	100%	✓	99.90%				100%			100%			100%			100%	
CAMHS	% of urgent assessments undertaken within 48 hours from receipt of referral (Crisis)	Sep-18	100%		100%	✓			94%	98%	91%	98%	100%	96%	100%	100%	100%	100%	100%	100%	
	% Patients with Neurodevelopmental Disorders (NDD) receiving a Diagnostic Assessment within 26 weeks	Sep-18	81%		80%	✓			59%	44%	93%	91%	95%	98%	94%	95%	91%	91%	87%	81%	
	P-CAHMS - % of Routine Assessment by CAMHS undertaken within 28 days from receipt of referral	Sep-18	18%		80%	✗			3%	3%	8%	9%	13%	9%	43%	38%	34%	23%	22%	18%	
	P-CAHMS - % of therapeutic interventions started within 28 days following assessment by LPMHSS	Sep-18	72%		80%	✗			100%	60%	56%	47%	88%	82%	62%	76%	80%	57%	93%	72%	
	S-CAHMS - % of Health Board residents in receipt of CAMHS to have a valid Care and Treatment Plan (CTP)	Sep-18	74%		90%	✗			73%	73%	73%	73%	79%	73%	75%	71%	76%	75%	75%	74%	
	S-CAHMS - % of Routine Assessment by SCAMHS undertaken within 28 days from receipt of referral	Sep-18	67%		80%	✗			43%	34%	32%	29%	41%	54%	63%	73%	70%	60%	52%	67%	

INDIVIDUAL CARE- People in Wales are treated as individuals with their own needs and responsibilities																							
Sub Domain	**Measure**	**Report Period**	**Current Performance**	**National Target**	**Annual Plan/ Local Profile**	**Profile Status**	**Welsh Average**	**Performance Trend**	**Oct-17**	**Nov-17**	**Dec-17**	**Jan-18**	**Feb-18**	**Mar-18**	**Apr-18**	**May-18**	**Jun-18**	**Jul-18**	**Aug-18**	**Sep-18**	**Oct-18**
Helplines	Rate of calls to the mental health helpline C.A.L.L. per 100k pop.	Q1 18/19	101.2	4 quarter ↑			173				122.1			107.5			101.2				
	Rate of calls to the Wales dementia helpline per 100k pop.	Q1 18/19	5.4	4 quarter ↑			8.6				5.1			4.4			5.4				
	Rate of calls to the DAN helpline per 100k pop.	Q1 18/19	33.7	4 quarter ↑			33.9				25.9			36.3			33.7				
Mental Health	% residents in receipt of secondary MH services (all ages) who have a valid care and treatment plan (CTP)	Sep-18	91%	90%	90%	✔	88.0%		90%	90%	89%	89%	89%	89%	90%	90%	88%	88%	90%	91%	
	% residents assessed under part 3 to be sent their outcome assessment report 10 working days after assessment	Sep-18	100%	100%	100%	✔	100.0%		100%	100%	100%	96%	100%	100%	100%	100%	100%	100%	100%	100%	
Patient Experience	Number of friends and family surveys completed	Oct-18	5,536		12 month ↑	✔			6,375	6,136	4,318	5,230	5,685	5,126	4,638	3,086	6,246	5,563	5,609	4,804	5,536
	% of who would recommend and highly recommend	Oct-18	96%		90%	✔			95%	96%	95%	95%	95%	95%	95%	95%	96%	96%	95%	96%	96%
	% of all-Wales surveys scoring 9 out 10 on overall satisfaction	Oct-18	86%		90%	✘			83%	84%	84%	83%	87%	84%	87%	89%	84%	85%	87%	89%	86%

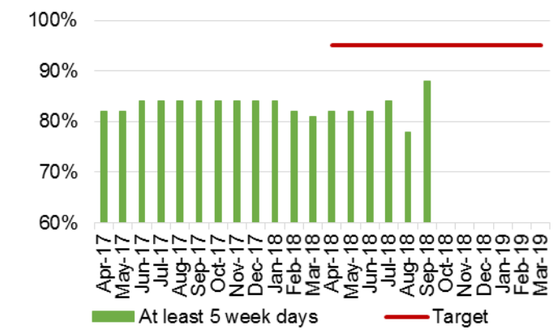
Sub Domain	**Measure**	**Report Period**	**Current Performance**	**National Target**	**Annual Plan/ Local Profile**	**Profile Status**	**Welsh Average**	**Performance Trend**	**Oct-17**	**Nov-17**	**Dec-17**	**Jan-18**	**Feb-18**	**Mar-18**	**Apr-18**	**May-18**	**Jun-18**	**Jul-18**	**Aug-18**	**Sep-18**	**Oct-18**
DNAs	% of patients who did not attend a new outpatient appointment	Oct-18	5.4%	12 month ↓	5.7%	✔	6.8%		6.4%	5.8%	6.6%	5.9%	5.9%	5.6%	6.2%	5.7%	5.5%	6.0%	5.4%	5.4%	5.4%
	% of patients who did not attend a follow-up outpatient appointment	Oct-18	6.8%	12 month ↓	7.5%	✔	7.9%		8.1%	7.7%	8.5%	8.0%	7.7%	7.1%	6.7%	6.8%	6.2%	7.0%	6.6%	6.4%	6.8%
Theatre Efficiencies	Theatre Utilisation rates	Oct-18	73%		90%	✘			75%	72%	72%	73%	73%	70%	72%	76%	74%	69%	62%	74%	73%
	% of theatre sessions starting late	Oct-18	41%		25%	✔			41%	42%	40%	43%	43%	46%	41%	41%	41%	38%	42%	39%	41%
	% of theatre sessions finishing early	Oct-18	39%		20%	✘			36%	35%	37%	34%	36%	43%	39%	37%	39%	40%	36%	36%	39%
Prescribing	Biosimilar medicines prescribed as % of total 'reference' product plus biosimilar	Q1 18/19	20.9%	Quarter on quarter ↑			14.9%				12.3%			12.2%			20.9%				
Elective Procedures	Elective caesarean rate	2017/18	13%	Annual ↓			12.8%		2017/18=13.2%												
Workforce	% of headcount by organisation who have had a PADR/medical appraisal in the previous 12 months (excluding doctors and dentists in training)	Oct-18	67%	85%	72%	✘	67.4%		63%	64%	64%	64%	63%	64%	64%	63%	63%	65%	65%	65%	67%
	% staff who undertook a performance appraisal who agreed it helped them improve how they do their job	2018	55%	Improvement			54%		2016= 55%			2018= 55%									
	Overall staff engagement score – scale score method	2018	3.81	Improvement			3.82		2016= 3.68			2018= 3.81									
	% compliance for all completed Level 1 competency with the Core Skills and Training Framework	Oct-18	67%	85%	52%	✔	73.4%		47%	48%	49%	49%	50%	51%	53%	55%	57%	59%	63%	65%	67%
	% workforce sickness and absent (12 month rolling)	Sep-18	5.91%	12 month ↓			5.27%		5.57%	5.59%	5.60%	5.65%	5.71%	5.76%	5.77%	5.81%	5.84%	5.87%	5.88%	5.91%	
	% staff who would be happy with the standards of care provided by their organisation if a friend or relative needed treatment	2018	72%	Improvement			73%		2016= 70%			2018= 72%									

4.1 Unscheduled Care- Overview

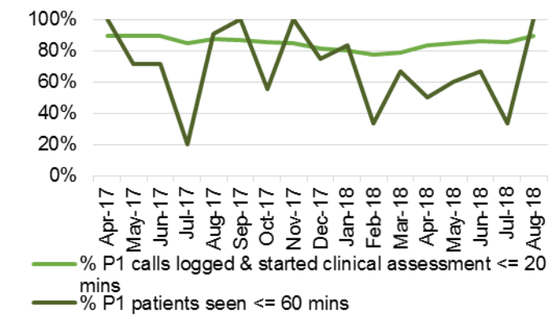
% GP practices open during core hours or within 1 hour of daily core hours



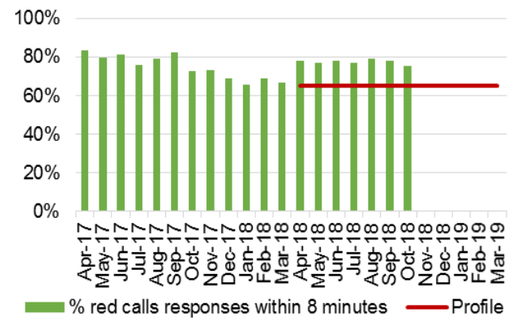
% GP practices offering daily appointments between 5pm- 6:30pm



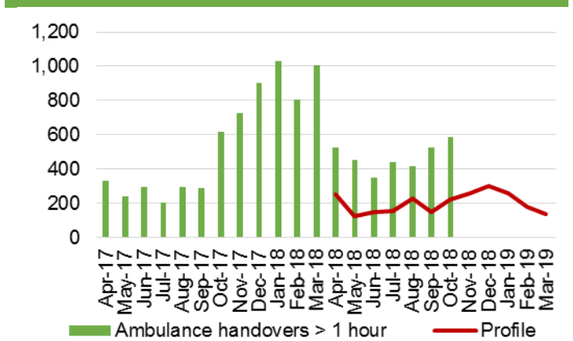
GP Out of Hours



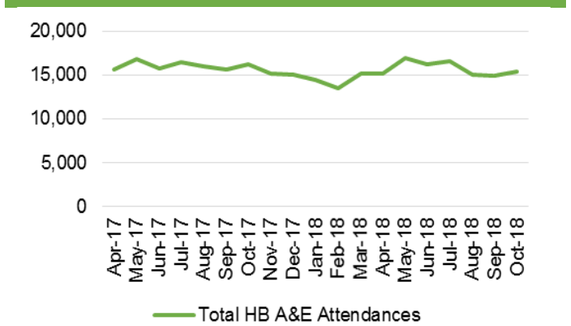
% red calls responded to within 8 minutes



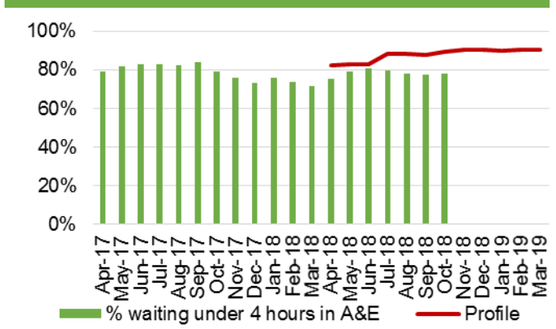
Number of ambulance handovers over 1 hour



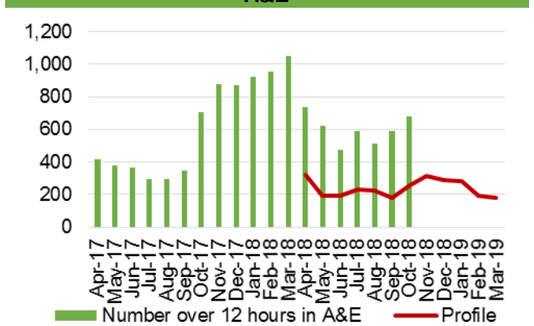
A&E Attendances



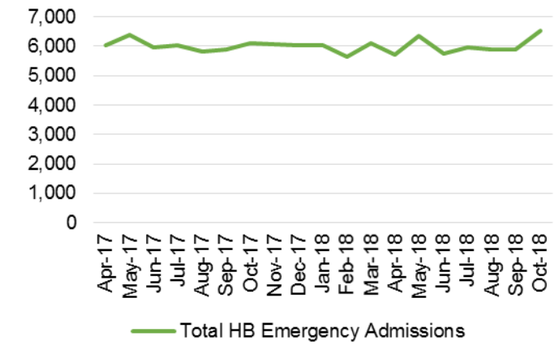
% patients who spend less than 4 hours in A&E



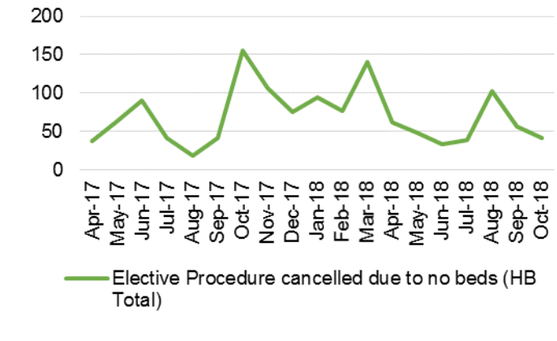
Number of patients waiting over 12 hours in A&E



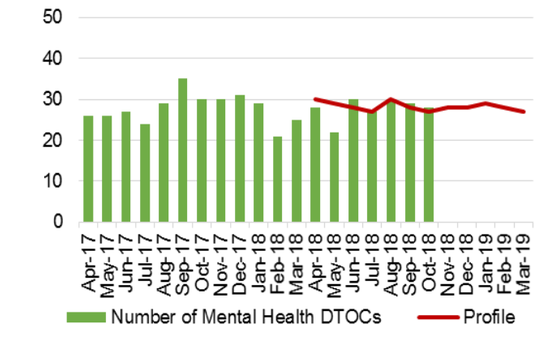
Number of emergency admissions



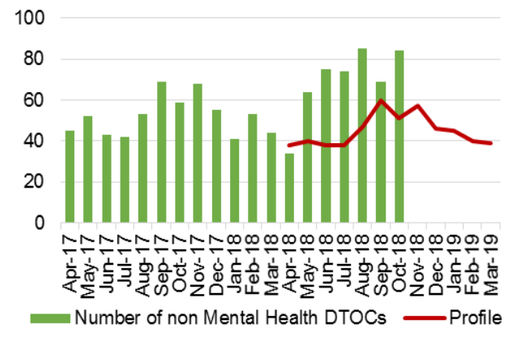
Elective procedures cancelled due to lack of beds



Number of mental health delayed transfers of care



Number of non- mental health delayed transfers of care



Unscheduled Care Overview (October 2018)

Primary Care Access

95% (5%↑)
GP practices open during daily core hours *(Sep-18)*

88% (10%↑)
GP practices offering appointments between 5pm-6:30pm *(Sep-18)*

89% (4%↑)
P1 calls started assessment within 20 minutes *(Aug-18)*

100% (67%↑)
P1 calls seen within 60 minutes *(Aug-18)*

Ambulance

75.4% (3%↓)
Red calls responded to with 8 minutes

590 (12%↑)
Ambulance handovers over 1 hour

8%↓
Amber calls

5%↑
Red calls

Emergency Department

15,434 (3%↑)
A&E attendances

77.96% (0.4%↑)
Waits in A&E under 4 hours

680 (16%↑)
Waits in A&E over 12 hours

16% (3%↑)
Patients admitted from A&E

Emergency Activity

6,516 (11%↑)
Emergency Inpatient Admissions

481 (7%↓)
Emergency Theatre Cases

405 (21%↑)
Trauma theatre cases

42 (26%↓)
Elective procedures cancelled due to no beds

Patient Flow

28 (7%↓)
Mental Health DTOCs

84 (42%↑)
Non-Mental Health DTOCs

276 (3%↓)
Medically fit patients

1,741 (20%↑)
Days lost due to medically fit *(Morriston only)*

1,403 (23%↑)
Medical outliers

Overarching Public Health Outcomes *(2016/17- 2017/18)*

43%
Staff uptake of flu vaccine (Oct-18)

20.5% (Wales= 19%)
Adults drinking above recommended guidelines

21.5% (Wales= 19%)
Adults who smoke

667.3 (Wales= 596.6)
Age standardisation rate of hip fractures among older people

35.3% (Wales= 35.9%)
Older people with healthy weight

41.8% (Wales= 47.1%)
Older people free from long term life limiting illnesses

**RAG status and trend is based on in month-movement*

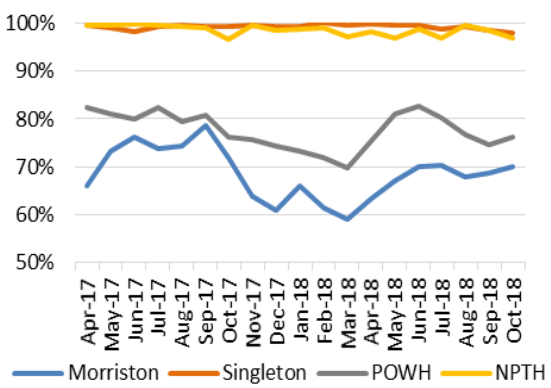
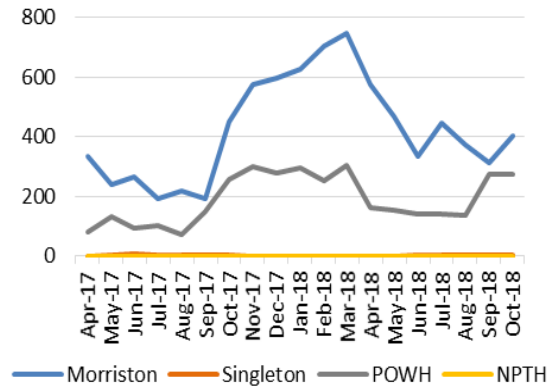
4.2 Winter Plan Dashboard

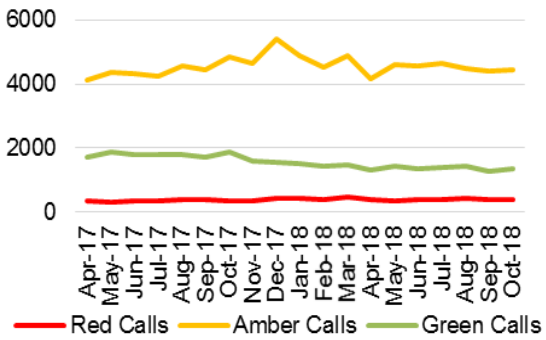
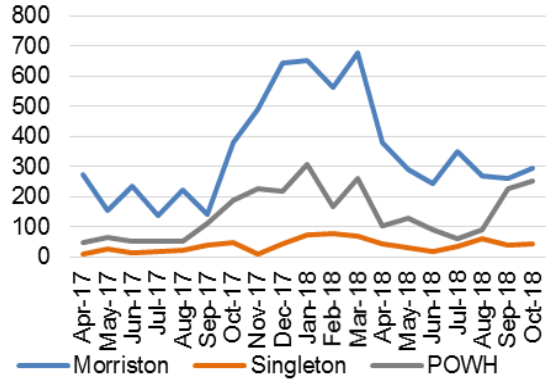
Quality & Performance Indicator	Measure	Report Period	Current Performance	In-month trend	Annual Comparison	Performance Trend	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18
Impact on unscheduled care standards	% of patients who spend less than 4 hours in all major and minor emergency care (i.e. A&E) facilities from arrival until admission, transfer or discharge	Oct-18	78.0%	⇧ 🟢	⇩ 🔴		79.1%	75.8%	73.4%	76.1%	73.8%	71.4%	75.6%	78.9%	81.0%	79.9%	77.9%	77.5%	78.0%
	Number of patients who spend 12 hours or more in all hospital major and minor care facilities from arrival until admission, transfer or discharge	Oct-18	680	⇧ 🔴	⇩ 🟢		706	875	871	924	957	1,051	737	624	476	590	511	588	680
	Number of ambulance handovers over one hour	Oct-18	590	⇧ 🔴	⇩ 🟢		617	727	903	1,030	805	1,006	526	452	351	443	420	526	590
	% of emergency responses to red calls arriving within (up to and including) 8 minutes	Oct-18	75.4%	⇩ 🔴	⇧ 🟢		73%	73%	69%	66%	69%	67%	78%	77%	78%	77%	79%	78%	75%
Delayed Transfers of care and medically fit for discharge numbers	Number of mental health HB DToCs	Oct-18	28	⇩ 🟢	⇩ 🟢		30	30	31	29	21	25	28	22	30	27	30	29	28
	Number of mental health HB DToCS (12 month rolling)	Oct-18	330	⇩ 🟢	⇧ 🔴		305	319	331	340	334	333	335	331	334	337	338	332	330
	Number of non-mental health HB DToCs	Oct-18	84	⇧ 🔴	⇧ 🔴		59	68	55	41	53	44	34	64	75	74	85	69	84
	Number of non-mental health HB DToCs (12 month rolling)	Oct-18	746	⇧ 🔴	⇧ 🔴		621	628	623	615	625	624	613	625	657	689	721	721	746
	Number of medically fit for discharge patients	Oct-18	276	⇩ 🟢	⇧ 🔴		196	195	174	233	187	184	285	276	260	254	230	285	276
Cancellations of operations for bed reasons	Number of elective procedures cancelled due to lack of beds	Oct-18	42	⇩ 🟢	⇩ 🟢		155	106	76	95	77	140	62	48	34	39	102	57	42
Critical care utilisation and delayed discharges							Under development/ validation												
Medical Outliers on non medical wards	Number of medical outliers on non-medical wards	Oct-18	1403	⇧ 🔴	⇧ 🔴		1,251	1,290	2,112	2,327	1,665	2,004	1,831	1,067	938	1,037	1,090	1,141	1,403
Use of pre-emptive/ boarding policy to place additional patients on wards							Under development/ validation												
Transfer times between hospitals within the health board							Under development/ validation												
Bed days lost due to delays in patient repatriation outside of the health board	Number of days lost where repatriation is the main reason for delay of discharge fit patient (Morriston Hospital only)	Oct-18	236	⇧ 🔴	⇧ 🔴		22	127	59	34	72	69	81	58	169	72	159	230	236

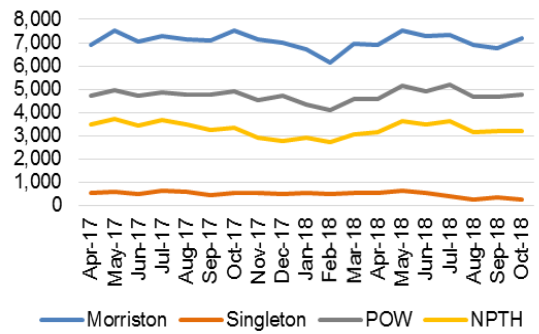
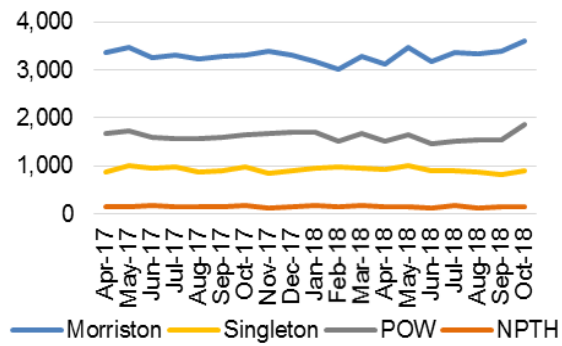
Quality & Performance Indicator	Measure	Report Period	Current Performance	In-month trend	Annual Comparison	Performance Trend	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18
Flu uptake rates	% uptake of influenza among 65 year olds and over	Oct-18	42.5%		⇧ 🟢		33%	66%	66%	68%	68%	68%							42.5%
	% uptake of influenza among under 65s in risk groups	Oct-18	25.3%		⇧ 🟢		18%	43%	43%	46%	47%	47%							25.3%
	% uptake of influenza among pregnant women											93%							
	% uptake of influenza among children 2 to 3 years old	Oct-18	20.4%		⇧ 🟢		7%	45%	45%	48%	49%	49%							20.4%
	% uptake of influenza among healthcare workers	Oct-18	43.2%		⇩ 🔴		49%	54%	55%	57%	58%	58%							43.2%
Home before lunch metrics							Under development/ validation												
Serious incidents in ED							Under development/ validation												
Datix reports on 12 hour waits in ED/ delayed patient handover from WAST							Under development/ validation												
Patient and staff experince (e.g. Friends and Family test)							Under development/ validation												

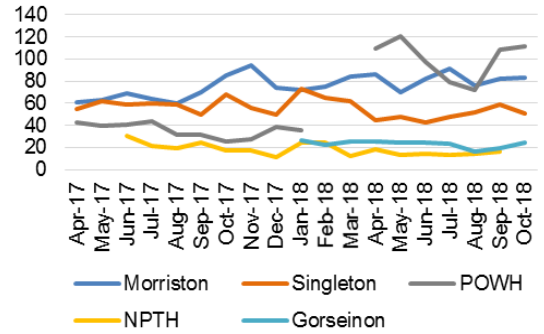
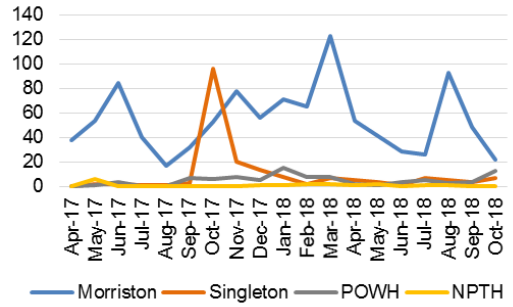
4.3 Unscheduled Care- Updates and Actions

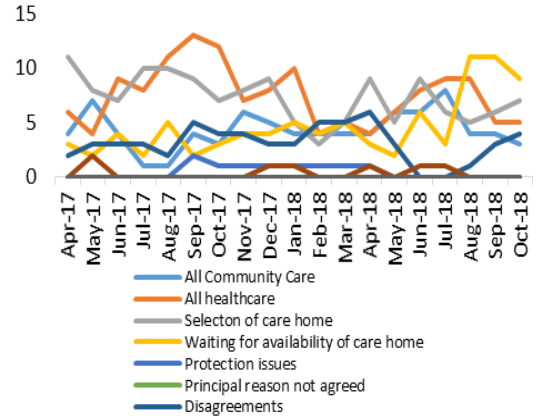
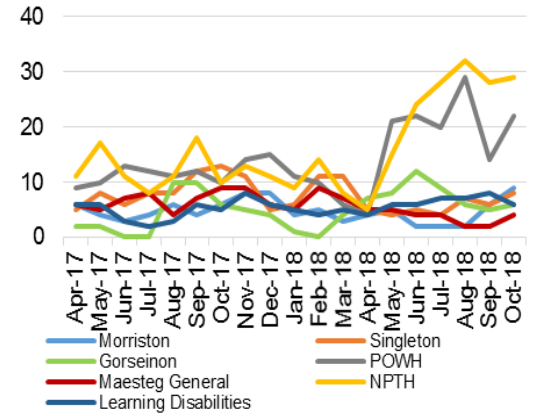
This section of the report provides further detail on key unscheduled care measures.

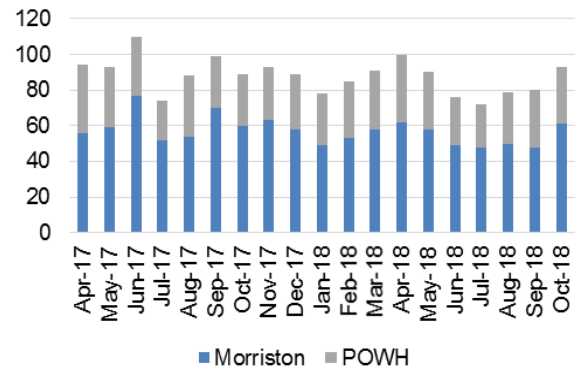
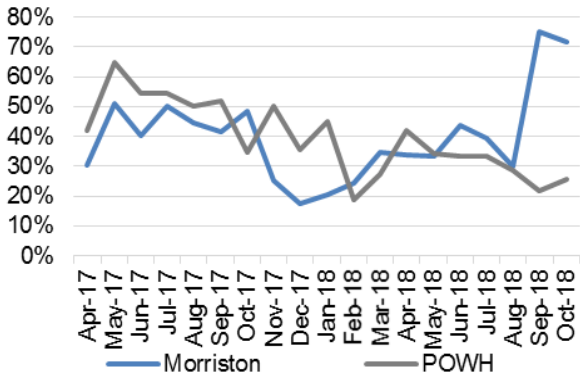
<table>
<tr><th>Description</th><th>Current Performance</th><th>Trend</th><th>Actions planned for next period</th></tr>
<tr><td>A&E waiting times
The percentage of patients who spend less than 4 hours in all major and minor emergency care facilities from arrival until admission, transfer or discharge</td><td>In October 2018 performance against the 4 hour metric improved from the position reported in September 2018 from 77.53% to 77.96% but was below the internal profile of 89.4%. Singleton and Neath Port Talbot Hospitals continue to exceed the national target of 95% but Morriston and Princess of Wales Hospitals are below profile, achieving 70% and 76% respectively.</td><td>% patients waiting under 4 hours in A&E
 
</td><td rowspan="2">• Implementation of Quarter 3 Unscheduled care improvement plans with a specific focus on:
○ Implementation of GP expected pathways and improved access to speciality services with additional hot clinics (Morriston).
○ Embedding the safety huddle approach which will strengthen daily patient flow processes at Morriston and rolling out this approach to Princess of Wales Hospital (POWH) and Neath Port Talbot Hospital (NPTH) by the end of November 2018.
○ Expand the opening hours of the medical day unit in Singleton and fully implement the integrated older persons service model at this hospital.
○ Systematic focus on improving the minor's workstream in the ED at POWH.
○ Developing the early supported discharge service which commenced in NPTH in mid-September.
• Implementation of the winter assurance planning arrangements.
• Reviewing boarding and escalation protocols under the leadership of the Director of Nursing and Patient experience.</td></tr>
<tr><td>A&E waiting times
The number of patients who spend 12 hours or more in all hospital major and minor care facilities from arrival until admission, transfer or discharge</td><td>Performance against this measure in October 2018 improved when compared with October 2017, with 25 fewer patients waiting >12 hours. In October 2018, the Health Board had 680 12 hour breaches of which 402 were attributed to Morriston Hospital, 275 to Princess of Wales Hospital and 3 to Singleton Hospital.</td><td>Number of patients waiting over 12 hours in A&E
 
</td></tr>
</table>

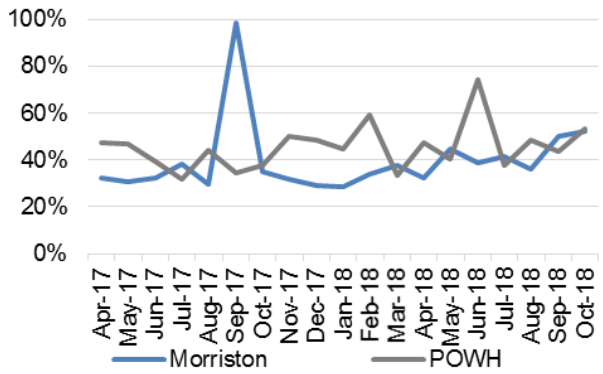
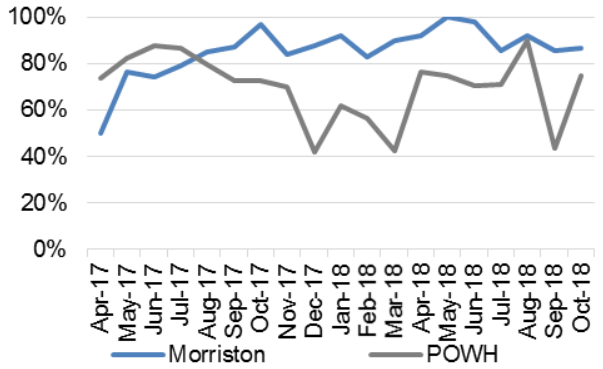
Description	Current Performance	Trend	Actions planned for next period
Ambulance responses The percentage of emergency responses to red calls arriving within (up to and including) 8 minutes. The number of responses to ambulance calls.	Ambulance response times are consistently above the national target and local profile of 65%, reporting 75.4% at the end of October 2018. The number and proportion of red call conveyances continues to increase, with Welsh Ambulance Services Trust (WAST) data suggesting that ABMU HB has the highest proportion of red calls in Wales for the population served.	**Number of ambulance call responses** 	• Work with WAST to direct patients to appropriate services or pathways, ensuring emergency ambulance capacity is utilised appropriately. Amber conveyances reduced by 10.5% (310 patients) in October 2018 compared with October 2017, although for the first time in many months there was a marginal increase in green call conveyances with 23 more patients in this category conveyed to hospital than in October 2017 (a 5% increase) • Await publication of National review of amber call demand at the end of October to inform further opportunities to improve ambulance response times and resource utilisation. • Implement the recommendations of the WAST internal audit report on hospital handover that are applicable to ABMU Health Board. • Implement Unscheduled care improvement plans to deliver system capacity to support timely patient handover. • The Health Board has jointly funded a patient Hospital Ambulance Liaison Officer (HALO) role with WAST to assist with hospital handover during the winter months.
Ambulance handovers The number of ambulance handovers over one hour	The number of ambulance handovers to local hospitals taking over 1 hour continues to be over profile which is a reflection of the pressures being felt across the unscheduled care system. In October 2018, Morriston Hospital saw a reduction of 87 compared with October 2017 (381 to 294). Princess of Wales Hospital (POWH) saw an increase of 65 (188 to 253) and Singleton Hospital saw a reduction of 5 (48 to 43).	**Number of ambulance handovers over one hour** 	

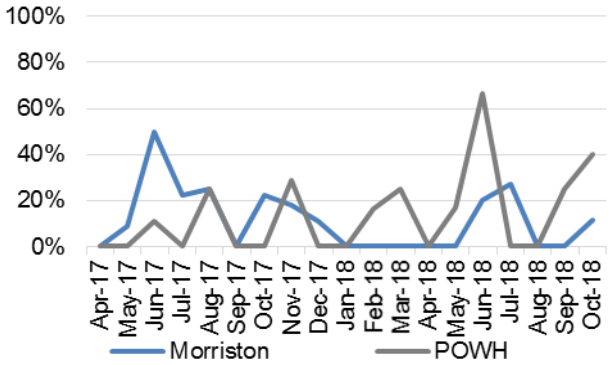
Description	Current Performance	Trend	Actions planned for next period
A&E Attendances The number of attendances at emergency departments in the Health Board	In October 2018, there were at total of 15,434 A&E attendances across the Health Board which is 837 less than October 2017: • Morriston Hospital: 4% reduction in attendances (7,507 to 7,196) • Singleton Hospital Minor Injury Unit (MIU): 50% reduction in attendances (540 to 268) • Princess of Wales Hospital: 2% reduction in attendances (4,897 to 4,779) • Neath Port Talbot Hospital MIU: 4% reduction in attendances (3,328 to 3,191).	**Number of A&E attendances** 	• Additional 111 awareness campaign communication programme underway as part of the winter planning arrangements – directories of service have been updated to support members of the public to choose well. • Implementation of workforce sustainability plan for out of hours service including recruitment of Nurse Clinical Lead for the multidisciplinary non-medical workforce. • 95% of ABMU community pharmacies now in a position to offer the Common Ailment Service (CAS). • Some GMS practices have increased their daytime opening hours to reach WG targets. Discussions with practices who do not meet the agreed standards and access is included in cluster plans and in the Health Board's clinical governance visiting programme. • Telephone first model to support practices to manage patient demand.
Emergency Admissions The number of emergency admissions across the Health Board by site	In October 2018, there were a total of 6,515 emergency admissions across the Health Board which is 411 more than October 2017 but 16 less than September 2018.	**Number of emergency admissions** 	• Recruitment of therapists to Swansea respiratory team to support patients at home, to avoid admission to hospital and to provide a consistent model across the Health Board (CNS's are in post). • Heart Failure at POWH- team set up and now fully established. Anticipate reduced admissions though direct referral to Heart Failure team and reduced length of stay. • Plan to introduce a falls vehicle in ABMU early November to support a reduction in the number of patients who have fallen, to be conveyed to hospital.

Description	Current Performance	Trend	Actions planned for next period
Medically Fit The number of patients waiting at each site in the Health Board that are deemed discharge/ medically fit	In October 2018, there were on average 270 patients who were deemed medically/ discharge fit but were still occupying a bed in one of the Health Board's Hospitals. This is a 38% increase when compared with October 2017. However it must be noted that data collection has significantly improved recently which could also attribute to the increase in numbers.	**The number of discharge/ medically fit patients by site**  ***Standardised collection of data from Gorseinon Hospital only commenced in January 2018 and no data available for POWH in February & March 2018.* ** Data for Gorseinon Hospital not available for September 2018.*	• Implementation and embedding the models of care to provide more timely discharge and value based care for frail older people. This includes the ICOP service at Singleton, the OPAS service at Morriston, the frailty service at POWH and the enabling ward and early supported discharge service at NPTH. • Promote and implement the SAFER flow principles. Develop the safety huddle approach to managing flow with the support of the NHS Wales Delivery Unit. Concerted focus on ensuring senior review is undertaken in a consistent way to ensure the provision of an agreed clinical management plan which is an essential part of the discharge process. • Following a review of the Western Bay optimal model in July and a presentation to the USC board in August, the Western Bay unscheduled care improvement plan is being revised. • Development of an electronic solution to capture live information on medically fit for discharge patients to improve communication and management of patient flow.
Elective procedures cancelled due to lack of beds The number of elective procedure cancelled across the hospital where the main cancellation reasons was	In October 2018, there were 113 less elective procedures cancelled due to lack of beds on the day of surgery when compared with September 2017 (155 to 42). Singleton was the main cause of the reduction with 7 procedures cancelled in October compared with 96 in October 2017.	**Total number of elective procedures cancelled due to lack of beds** 	• Ongoing implementation of models of care that mitigate the impact of unscheduled care pressures on elective capacity – such as ambulatory emergency care models and enhanced day of surgery models. • Maximise utilisation of surgical unit at NPT hospital which is not affected by emergency pressures.

Description	Current Performance	Trend	Actions planned for next period
Delayed Transfers of Care (DTOC) The number of DTOCs per Health Board- Mental Health (all ages)	The number of mental health related delayed transfers of care in October 2018 was one above the internal profile of 27.	**Number of Mental Health DToCs** 	• Discussions taking place with Local Authority (LA) partners at all levels to discuss collaborative opportunities to improve the discharge pathway and patient experience. • A proportion of the Health Board's winter pressures funding reserve has been allocated to Western Bay partners to enhance discharge capacity over the winter period. • Promote and implement the SAFER flow principles and to develop the safety huddle approach to managing flow with the support of the NHS Wales Delivery Unit • Develop a response to the findings of the bed utilisation review in Swansea and NPT hospitals undertaken on 04/10/18. • The Delivery Unit presented the findings of the complex discharge audit to the Unscheduled Care board in October. Additional opportunities identified to strengthen discharge improvement process across the system. A small number of priority areas will be recommended to the unscheduled care board meeting in November for implementation and focus over the remainder of the financial year. • Health Board participation at the national workshop on complex discharges on 8th November – learning will be used to strengthen our discharge processes. • Development of an electronic solution to capture live information on medically fit for discharge patients to improve multi agency communication and management of patient flow.
Delayed Transfers of Care (DTOC) The number of DTOCs per Health Board - Non Mental Health (age 75+)	In October 2018, the number of non-mental health and Learning disability delayed transfers of care was 84 which is higher than the internal profile of 51. Swansea Locality traditionally has the largest proportion of delays but in recent months NPT has had the largest proportion due to an increase in patients waiting LA placement of care or completion of assessment; and patients waiting for CRT input.	**Number of Non Mental Health DToCs** 	

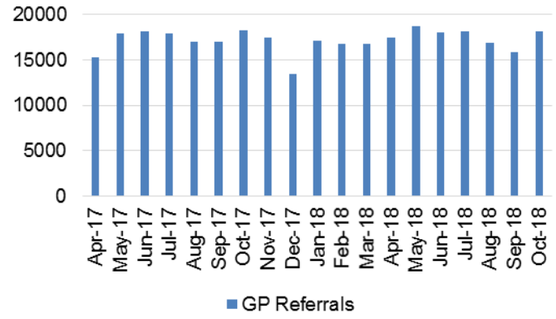
Description	Current Performance	Trend	Actions planned for next period
Stroke Admissions The total number of stroke admissions into the Health Board	In October 2018, there were 93 confirmed stroke admissions across the Health Board; 61 in Morriston and 32 in Princess of Wales. This is 4% more when compared with October 2017 (89 to 93).	**Total number of stroke admissions** 	• Roll out and support impact of the Directed Enhanced Service for INR and Direct-Acting Oral Anticoagulants (DOAC) service. • Business case to be developed following the success of Stroke Retrieval Pilot undertaken in Morriston during June. • An additional 6 Senior Clinical Fellows have been appointed to ensure two registrars are available from 10pm to 9:30am Midweek and on Weekends two registrars providing cover from 9am -2:00am the next morning. One registrar focuses on the ward cover and the other provides a presence in A&E for all conditions but including Stroke. • Duties of a Stroke Champion being nominated in OOH rotas underway – with appropriate duties / responsibilities being agreed.
Stroke 4 hour access target % of patients who have a direct admission to an acute stroke unit within 4 hours	In October 2018 only 51 out of 91 patients had a direct admission to an acute stroke unit within 4 hours (56%). The 4 hour target appears to be a challenge across Wales. The all-Wales data for October 2018 confirms that performance ranged from 41.8% to 79.1%. ABMU was the second best performing Health Board in October 2018.	**Percentage of patients admitted to stroke unit within 4 hours** 	• Monitor Morriston medical On-Call rota with the additional senior Medical staff to support greater cover into wards and medical cover to support A&E. • Complete additional training to improve swallow screening compliance within the Emergency department staff. • SLT recruitment discussion held with Chief Operating Officer (COO) with support given to increase recruitment to address shortfall. • POWH – will build on key Task and Finish groups to focus on improving stroke performance.

Description	Current Performance	Trend	Actions planned for next period
Stroke CT scan Percentage of patients who receive a CT scan within 1 hour	In October 2018, ABMU achieved 53% which was above the internal profile of 45%.	**Percentage of patients receiving CT scan within 1 hour** 	• IBG has considered the case for the development of an Early Supportive Discharge service at Morriston / Singleton hospitals – agreed that further work was required. Delivery Unit meetings to take place to update and agree next steps. • POWH have updated Clerking arrangements – process to be monitored to assess effectiveness. • The stroke team at POWH to continue working closely with the patient flow team to ensure a focus on stroke flow and a prioritisation for creating assessment capacity. • At Singleton the team will examine all processes including senior review / early discharge / effective Board rounds on ward 7. • Assessments and criteria between Ward F and ward 7 to continue. A National Thrombolysis review is underway with both Morriston and POWH being reviewed in November – data collection / protocols etc are currently being collated in readiness for that Peer review.
Stroke assessment within 24 hours Percentage of patients who are assessed by a stroke specialist consultant physician within 24 hours	In October 2018, ABMU achieved 83% which was above the internal profile of 80%.	**Percentage of patients assessed by stroke consultant within 24 hours** 	

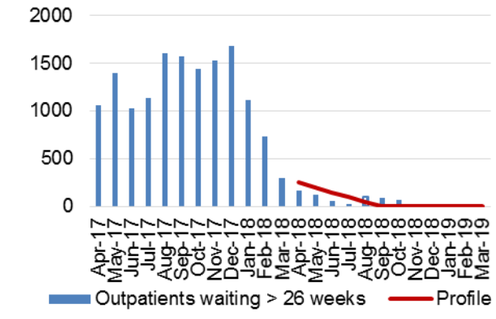
Description	Current Performance	Trend	Actions planned for next period
Thrombolysed Patients with Door-to-Needle <= 45 mins	In October 2018, 94.7% of eligible patients were thrombolysed and only one of the four patients were thrombolysed within the 45 minutes (door to needle) standard.	**Thrombolysed patients within 45 minutes** 	• As above

5.1 Planned Care- Overview

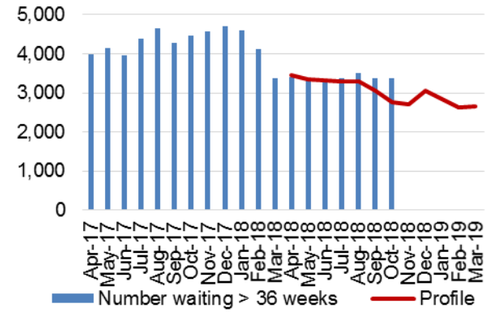
Number of GP Referrals into secondary care



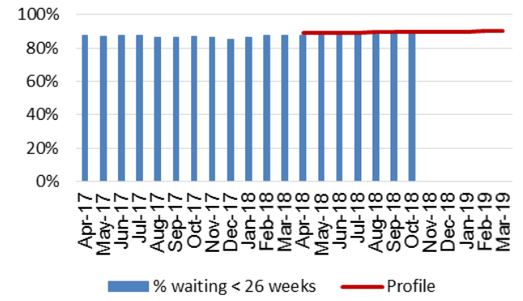
Number of patients waiting over 26 weeks for an outpatient appointment



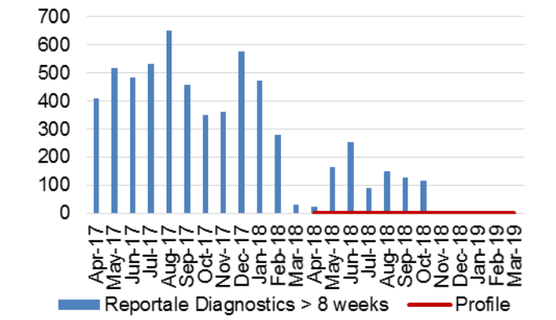
Number of patients waiting over 36 weeks for treatment



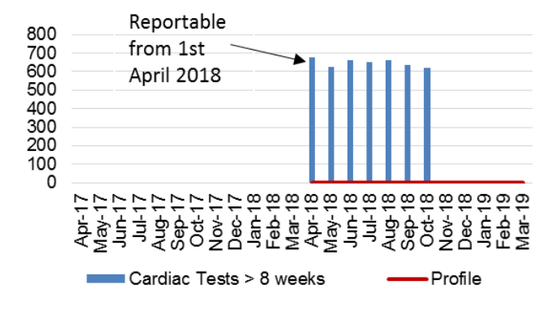
% patients waiting less than 26 weeks from referral to treatment



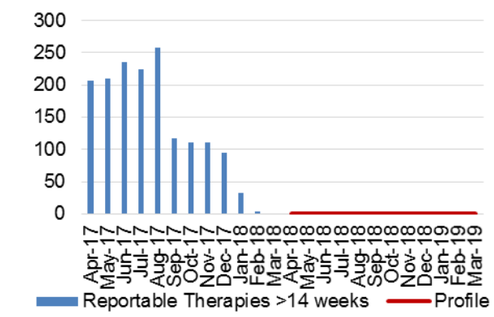
Number of patients waiting for reportable diagnostics over 8 weeks (excluding Cardiac)



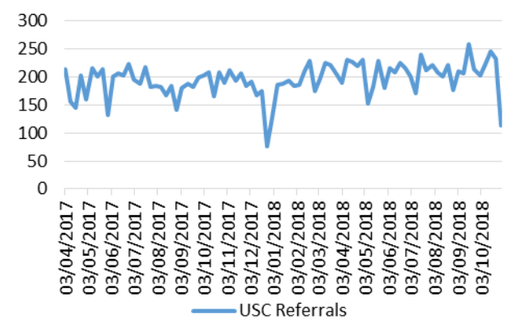
Number of patients waiting for reportable Cardiac diagnostics over 8 weeks



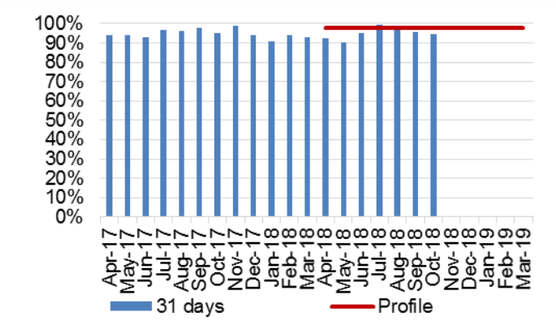
Therapies over 14 weeks



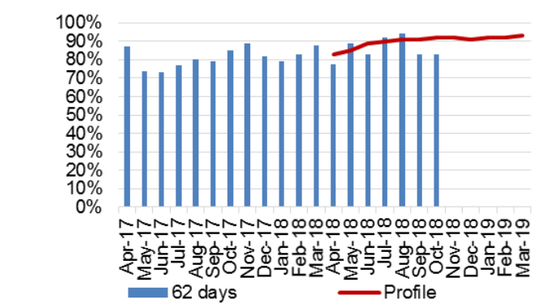
Cancer referrals



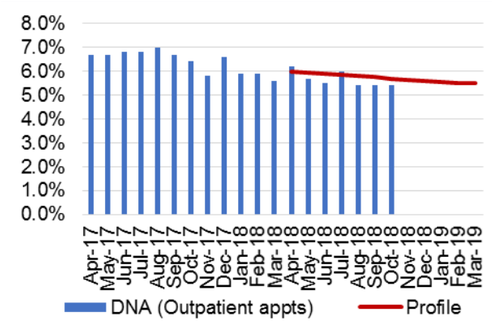
% patients newly diagnosed with cancer, not via the urgent route, that started definitive treatment within (up to & including) 31 days



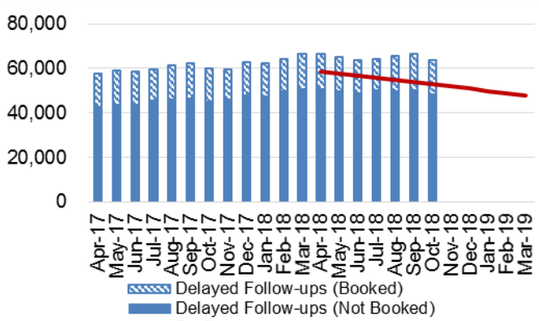
% patients newly diagnosed with cancer, via the urgent suspected cancer route, that started definitive treatment within (up to & including) 62 days of receipt of referral



% of patients who did not attend a new outpatient appointment *(for selected specialties)*



Number of patients waiting for an outpatient follow-up who are delayed past their target date



Planned Care- Overview (October 2018)

Demand

18,967 (15%↑)
Total GP referrals

11,402 (14%↑)
Routine GP referrals

7,565 (16%↑)
Urgent GP referrals

Waiting Times

65 (27%↓)
Patients waiting over 26 weeks for a new outpatient appointment

3,370 (0.3%↓)
Patients waiting over 36 weeks for treatment

1,477 (1.3%↓)
Patients waiting over 52 weeks for treatment

89.1% (→)
Patients waiting under 26 weeks from referral to treatment

116 (9%↓)
Patients waiting over 8 weeks for reportable diagnostics

619 (3%↓)
Patients waiting over 8 weeks for Cardiac diagnostics

0 (→)
Patients waiting over 14 weeks for reportable therapies

63,538 (4.1%↓)
Patients waiting for an outpatient follow-up who are delayed past their target date

Outpatient Efficiencies

6% (→)
% of patients who did not attend a new outpatient appointment

7.6% (0.2%↑)
% of patients who did not attend a follow-up outpatient appointment

Cancer

113 (47.2%↓)
USC referrals

97 (18%↓)
USC backlog over 52 days

83.1% (0.2%↓)
USC patients receiving treatment within 62 days

94.4% (1.3%↓)
NUSC patients receiving treatment within 31 days

Theatre Efficiencies

73% (1%↓)
Theatre utilisation rate

41% (2%↑)
% of theatres sessions starting late

39% (3%↑)
% of theatres sessions finishing early

38% (7%↑)
Operations cancelled on the day

Overarching Public Health Outcomes (2016/17- 2017/18)

50% (Wales= 53.2%)
Adults meeting physical activity guidelines

20.8% (Wales= 23.8%)
Adults eating 5 fruit or vegetables a day

73.3% (Wales= 72.9%)
Children age 5 of healthy weight or underweight

76.6% (Wales= 75.9%)
Adolescents of healthy weight

39.2% (Wales 39.2%)
Working age adults of healthy weight

35.3% (Wales= 35.9%)
Older people of healthy weight

1.2 (Wales=1.2)
Average decayed, missing or filled teeth among 5 year olds

73.3% (Wales=75.9%)
Working age adults in good health

55% (Wales 56.7%)
Older people in good health

67.5% (Wales= 73)
Working age adults free from life limiting long term illnesses

41.8% (Wales= 47.1%)
Older people free from life limiting long term illnesses

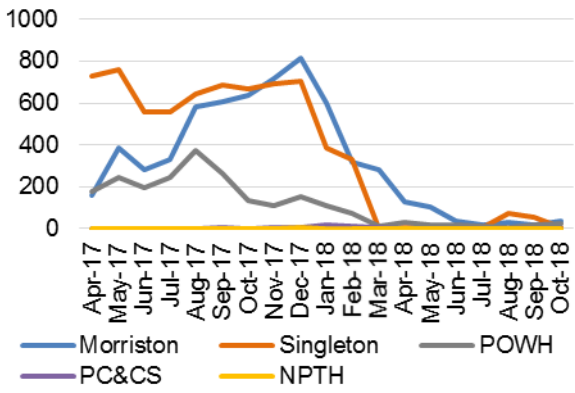
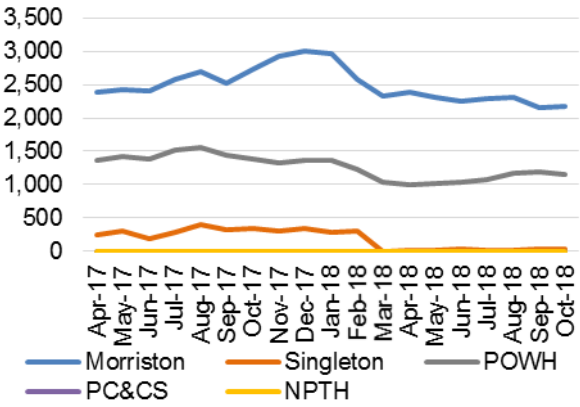
**RAG status and trend is based on in month-movement*

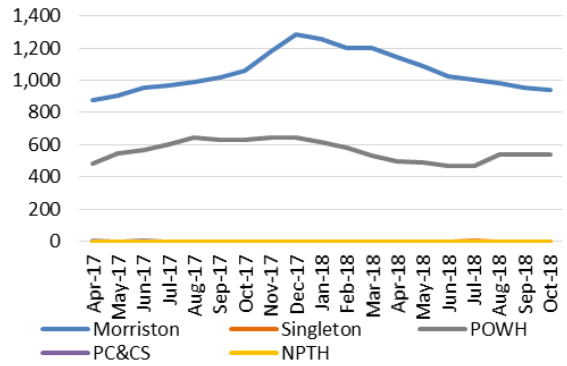
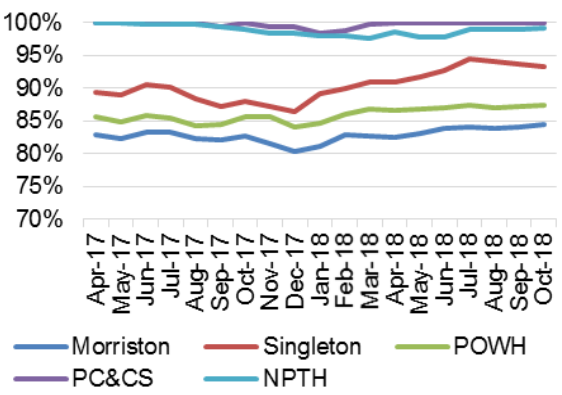
5.2 Theatre Efficiencies Dashboard

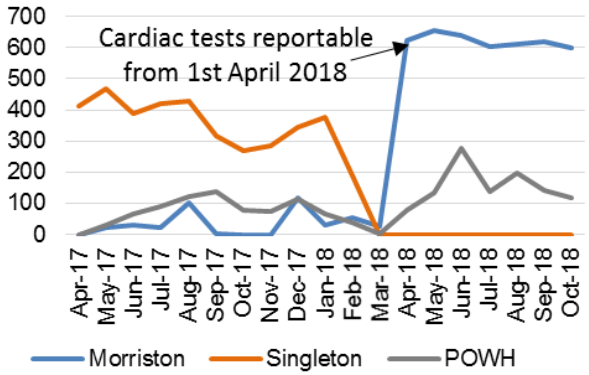
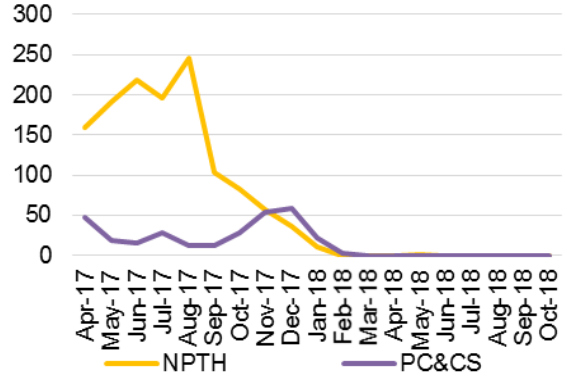
Measure			Report Period	Current Performance	Initial Target	Target Status	In-month trend	Annual Comparison	Performance Trend	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18
Number of cancelled operations	Morriston		Oct-18	458		✖				411	356	357	368	319	441	305	433	471	409	390	396	458
	NPTH		Oct-18	181		✖				190	161	116	180	205	181	148	149	161	135	174	182	181
	POWH		Oct-18	363		✖				312	316	272	320	321	396	336	323	399	376	287	322	363
	Singleton		Oct-18	223		✖				241	173	174	173	159	214	161	202	169	170	217	158	223
	HB Total		Oct-18	1225		✖				1154	1006	919	1041	1004	1232	950	1107	1200	1090	1068	1058	1225
% of cancelled operations on the day	Morriston		Oct-18	44%	10%	✖				43%	38%	32%	45%	51%	40%	40%	32%	28%	27%	35%	34%	44%
	NPTH		Oct-18	22%		✖				22%	31%	31%	26%	26%	24%	24%	29%	29%	24%	25%	21%	22%
	POWH		Oct-18	31%		✖				40%	34%	36%	33%	36%	43%	34%	31%	35%	33%	37%	28%	31%
	Singleton		Oct-18	48%		✖				40%	42%	50%	47%	45%	43%	50%	49%	41%	38%	31%	42%	48%
	HB Total		Oct-18	38%		✖				38%	37%	37%	38%	40%	39%	37%	34%	32%	31%	33%	31%	38%
Reasons for cancellations on the day	Hospital Clinical		Oct-18	25%						30%	27%	28%	35%	32%	31%	35%	30%	31%	32%	26%	32%	25%
	Hospital Non-Clinical		Oct-18	46%						47%	44%	51%	42%	40%	39%	34%	42%	42%	41%	49%	41%	46%
	Other		Oct-18	0%						0%	0%	0%	0%	0%	8%	0%	0%	1%	0%	0%	0%	0%
	Patient		Oct-18	29%						22%	28%	21%	24%	28%	21%	30%	28%	26%	27%	24%	26%	29%
	Unknown		Oct-18	0%						0%	1%	0%	0%	0%	0%	0%	1%	1%	0%	1%	1%	0%
Late Starts	Morriston		Oct-18	35%	25%	✖				50%	47%	40%	43%	46%	50%	45%	37%	37%	37%	49%	38%	35%
	NPTH		Oct-18	36%		✖				25%	38%	35%	33%	35%	39%	39%	28%	30%	36%	20%	36%	36%
	POWH		Oct-18	42%		✖				33%	39%	39%	43%	35%	41%	38%	44%	40%	35%	38%	38%	42%
	Singleton		Oct-18	53%		✖				41%	39%	43%	47%	51%	46%	42%	52%	55%	43%	43%	45%	53%
	HB Total		Oct-18	41%		✖				41%	42%	40%	43%	43%	46%	41%	41%	41%	38%	42%	39%	41%
Early Finishes	Morriston		Oct-18	34%	20%	✖				27%	29%	36%	31%	36%	41%	39%	33%	33%	34%	30%	25%	34%
	NPTH		Oct-18	62%		✖				56%	53%	52%	48%	54%	58%	39%	60%	58%	61%	59%	62%	62%
	POWH		Oct-18	38%		✖				43%	38%	34%	33%	37%	43%	37%	36%	44%	43%	35%	41%	38%
	Singleton		Oct-18	34%		✖				36%	32%	35%	32%	27%	36%	44%	34%	33%	36%	38%	34%	34%
	HB Total		Oct-18	39%		✖				36%	35%	37%	34%	36%	43%	39%	37%	39%	40%	36%	36%	39%
Theatre Utilisation Rate	Morriston		Oct-18	80%	90%	✖				85%	84%	74%	80%	79%	79%	78%	85%	79%	75%	70%	82%	80%
	NPTH		Oct-18	70%		✖				69%	63%	68%	70%	65%	58%	69%	63%	62%	63%	44%	67%	70%
	POWH		Oct-18	70%		✖				72%	73%	80%	69%	72%	70%	72%	76%	77%	71%	61%	72%	70%
	Singleton		Oct-18	62%		✖				56%	63%	61%	62%	63%	54%	60%	61%	63%	55%	53%	62%	62%
	HB Total		Oct-18	73%		✖				75%	72%	72%	73%	73%	70%	72%	76%	74%	69%	62%	74%	73%
Theatre Activity Undertaken	Morriston	Day cases	Oct-18	371						290	299	273	284	299	321	312	269	310	302	368	272	371
		Emergency cases	Oct-18	335						401	340	380	346	324	335	354	387	374	375	391	373	335
		Inpatients	Oct-18	572						669	587	480	559	522	478	527	630	543	497	486	522	572
	NPTH	Day cases	Oct-18	347						311	233	185	261	285	257	267	240	214	234	190	290	347
		Emergency cases	Oct-18	5						6	13	6	15	1	7	3	5	9	6	5	8	5
		Inpatients	Oct-18	133						120	133	95	141	127	106	126	147	138	122	89	116	133
	POWH	Day cases	Oct-18	455						434	398	311	472	395	371	350	429	449	408	301	393	455
		Emergency cases	Oct-18	107						123	91	125	120	100	139	107	125	120	120	126	101	107
		Inpatients	Oct-18	264						234	253	192	162	225	234	262	238	252	251	236	223	264
	Singleton	Day cases	Oct-18	516						537	569	388	509	461	439	462	526	500	445	456	423	516
		Emergency cases	Oct-18	34						29	27	40	40	41	49	35	38	52	45	44	34	34
		Inpatients	Oct-18	141						122	129	85	118	123	91	124	127	120	90	102	98	141

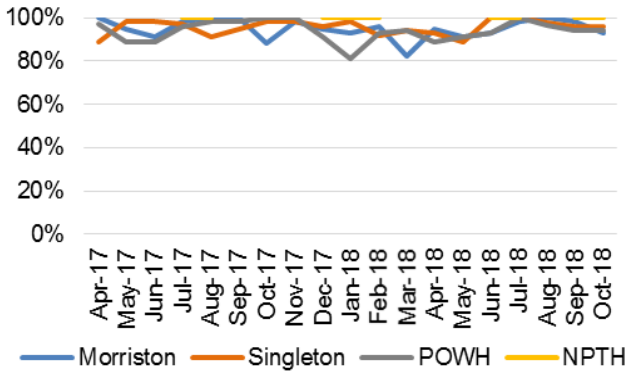
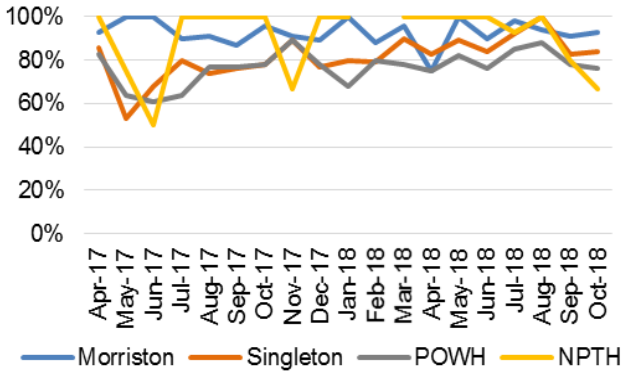
5.3 Planned Care Updates and Actions

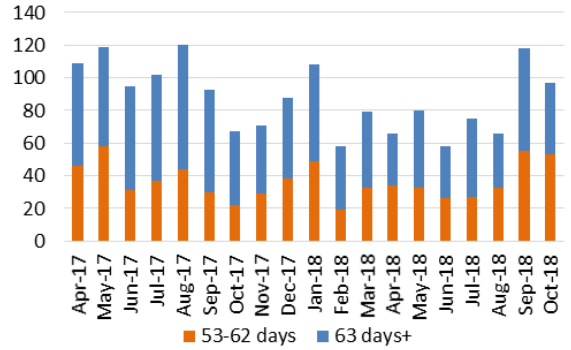
This section of the report provides further detail on key planned care measures.

Description	Current Performance	Trend	Actions planned for next period
Outpatient waiting times The number of patients waiting more than 26 weeks for an outpatient appointment (stage 1)	The number of patients waiting over 26 weeks for a first outpatient appointment continues to be significantly lower than in previous years. In October 2018 there were 65 patients waiting over 26 weeks which is a reduction on the previous month and 1,373 less than October 2017. In October 2018, 32% of the breaches were in Urology (21 breaches).	**Number of stage 1 over 26 weeks** 	• Core capacity being maximised and additional clinics continue to be secured. • Ophthalmology consultants returning in October/November. Outsourcing of cataract cases agreed in the interim to manage the backlog. New Glaucoma consultant commencing in November. • Fragility of Urology service due to consultant sickness and restricted working following return from sick leave continue to be a challenge. Locum in place as an interim measure and discussions with Morriston and Cwm Taf regarding support are taking place.
Total waiting times The number of patients waiting more than 36 weeks for treatment	The number of patients waiting longer than 36 weeks from referral to treatment continues to be a challenge. In October 2018 there were 1,093 less patients waiting over 36 weeks compared with October 2017. 97% of patients are waiting in the treatment stage of the pathway and Orthopaedics accounts for 58% of the breaches, followed by General Surgery with 16%.	**Number of patients waiting longer than 36 weeks** 	• Orthopaedics:- ○ Increased outsourcing underway ○ Weekend Arthroplasty lists commenced at NPTH, undertaking two cases per week with potential to increase. ○ Workforce training/redesign to provide an element of cover for theatre nursing staffing deficits at Morriston in place whilst recruitment programme is underway. ○ Theatre lists at Royal Glamorgan Hospital due to take place the last week in November. ○ Consider the incentives to engage staff to work out of hours or on weekends to create additional capacity within existing infrastructure

Description	Current Performance	Trend	Actions planned for next period
Total waiting times The number of patients waiting more than 52 weeks for treatment	The number of patients waiting over 52 weeks mirrors that of the 36 week position with Orthopaedics and General Surgery accounting for the vast majority of breaches. In October 2018 the position has seen a small in-month improvement of 20 and is 252 ahead of the March 2018 position.	**Number of patients waiting longer than 52 weeks** 	• The actions relating to > 52 week patients are the same as 36 week patients. • Targeted treat in turn and clinical discussions to prioritise longest waiting patients. • Units challenged to produce sustainable step change plans to maintain continual improvement and compress the tail end of the longest waiting patients.
Total waiting times Percentage of patients waiting less than 26 weeks from referral to treatment	Throughout 2017/18 the overall percentage of patients waiting less than 26 weeks from referral to treatment has been consistently around 86%. So far in 2018/19 the percentage continues to improve and October 2018 maintained the same position as September 2018 with 89.1%. This position is still the highest percentage since November 2013.	**Percentage of patient waiting less than 26 weeks** 	• Plans as outlined in previous tables.

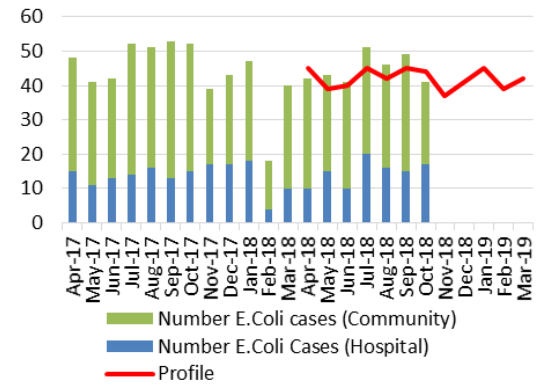
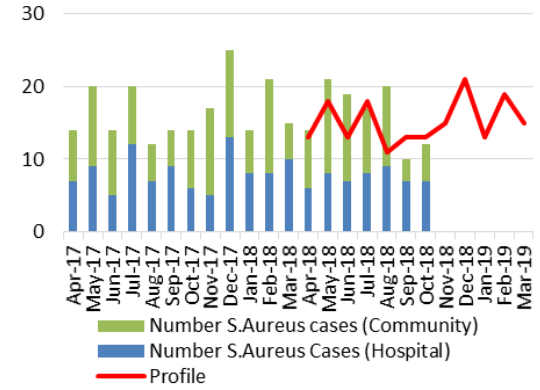
Description	Current Performance	Trend	Actions planned for next period
Diagnostics waiting times The number of patients waiting more than 8 weeks for specified diagnostics	In October 2018, there were 717 patients waiting over 8 weeks for specified diagnostics. The noticeable increase in breaches is due to the introduction of new Cardiac diagnostic tests in April 2018. The main elements of the 717 breaches are split as follows: • Non Obstetric Ultrasound (POWH)= 116 • Cardiac Tests= 601	**Number of patients waiting longer than 8 weeks for diagnostics** 	• Sustain Nil position for Endoscopy by maximising backfill and WLIs. • Additional lists, outsourcing and redesign of skill mix for non-obstetric ultrasound cases. One sonographer appointed and being used to focus on backlog. • Implement additional cardiac CT/MR capacity:- ○ New core CT list at POWH commenced. ○ CT lists agreed with the Institute of Life Sciences commencing in November ○ MR sessions agreed within job plans to commence first week in December subject to the availability of a mobile unit to manage the displaced non-cardiac activity.
Therapy waiting times The number of patients waiting more than 14 weeks for specified therapies	There has been significant improvement in Therapy waiting times over the last 12 months and there were no patients waiting over 14 weeks in April 2018. The October 2018 position shows a Nil position for Therapies waiting over 14 weeks.	**Number of patients waiting longer than 14 weeks for therapies** 	• Continuation of current plans to manage patients into early appointments to provide headroom for re-booking any late cancellations.

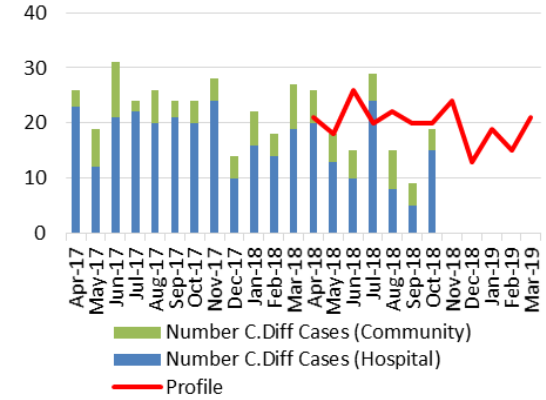
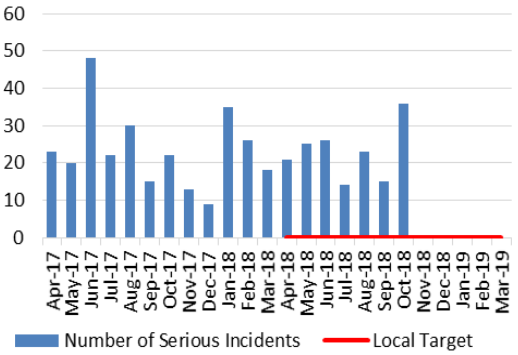
Description	Current Performance	Trend	Actions planned for next period
Cancer- NUSC waiting times- Percentage of patients newly diagnosed with cancer, not via urgent route that started definitive treatment within 31 days of diagnosis	October 2018 figures will be finalised on 30th November. Draft figures indicate projected achievement of 94% of patients' starting treatment within 31 days. At the time of writing this report there are 8 breaches across the Health Board in October 2018: • Urological: 3 • Skin: 3 • Gynaecological: 1 • Other: 1	**Percentage of NUSC patients starting treatment within 31 days of diagnosis** 	• Additional weekend surgical lists during November and into December (6 weeks) in Gynae-oncology. • Review of the practice around authorisation of Annual Leave of medical staff to be progressed with the Medical Director.
Cancer- USC waiting times- Percentage of patients newly diagnosed with cancer, via the urgent suspected cancer route, that started definitive treatment within 62 days of receipt of referral	October 2018 figures will be finalised on 30th November. Draft figures indicate a projected achievement of 83% of patients starting treatment within 62 days. At the time of writing this report there are 30 breaches in total across the Health Board: • Urological: 9 • Gynaecological: 5 • Breast: 5 • Lower Gastrointestinal: 4 • Upper Gastrointestinal: 2 • Haematology: 2 • Other: 1 • Lung: 1 • Head & Neck: 1	**Percentage of USC patients starting treatment within 62 days of receipt of referral** 	• Endoscopy capacity and demand modelling has been undertaken, Informatics to programme a live dashboard in November. This will be used for the service to monitor demand and activity whilst reviewing variance within the service and contracted sessions. • Detailed Radiology Demand and Capacity plan including reporting time requirements is being finalised. Informatics to include priority flags within data warehouse during November in order to develop this further.

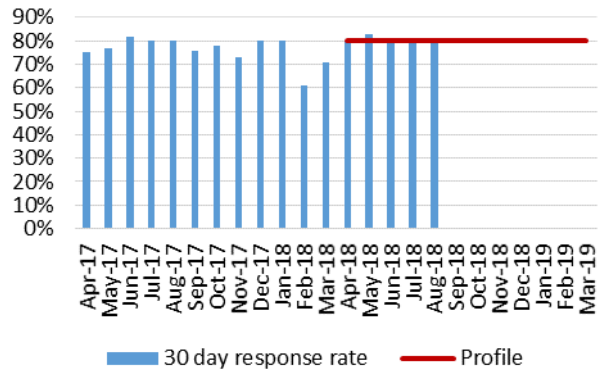
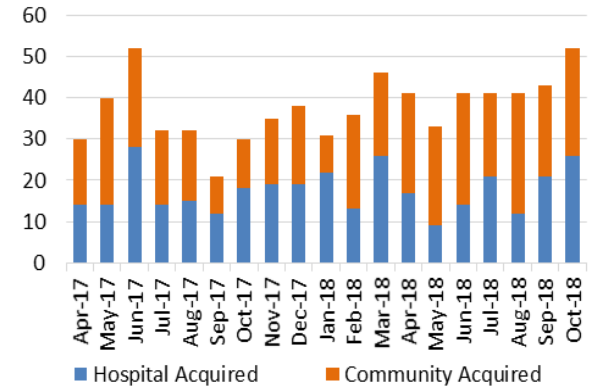
<table>
<tr><th>Description</th><th>Current Performance</th><th>Trend</th><th>Actions planned for next period</th></tr>
<tr>
<td>USC backlog
The number of patients with an active wait status of more than 53 days</td>
<td>End of October 2018 backlog by tumour site:
<table>
<tr><th>Tumour Site</th><th>53 - 62 days</th><th>63 ></th></tr>
<tr><td>Breast</td><td>7</td><td>2</td></tr>
<tr><td>Gynaecological</td><td>21</td><td>12</td></tr>
<tr><td>Haematological</td><td>1</td><td>2</td></tr>
<tr><td>Head and Neck</td><td>3</td><td>2</td></tr>
<tr><td>Lower GI</td><td>5</td><td>5</td></tr>
<tr><td>Lung</td><td>3</td><td>3</td></tr>
<tr><td>Other</td><td>3</td><td>1</td></tr>
<tr><td>Skin</td><td>1</td><td>0</td></tr>
<tr><td>Upper GI</td><td>2</td><td>5</td></tr>
<tr><td>Urological</td><td>7</td><td>12</td></tr>
<tr><td>Grand Total</td><td>53</td><td>44</td></tr>
</table>
</td>
<td>Number of patients with a wait status of more than 53 days
 
</td>
<td>• PMB One-stop clinic commenced 5th November. Current waiting list for PMB is short and capacity converted to outpatient hysteroscopy to reduce waits for patients following the previous clinic model.
• Recommendations to improve processes for tracking to be progressed. DU's have indicated resources required that will be taken forward as actions of the Cancer Report during later November/early December.</td>
</tr>
<tr>
<td>USC First Outpatient Appointments
The number of patients at first outpatient appointment stage by days waiting</td>
<td>Week to week through October 2018 the percentage of patients seen within 14 days to first appointment/assessment ranged between 28% and 37%.</td>
<td>The number of patients waiting for a first outpatient appointment (by total days waiting) - End of October 2018
<table>
<tr><th></th><th>≤10</th><th>11-20</th><th>21-30</th><th>>31</th><th>Total</th></tr>
<tr><td>Breast</td><td>6</td><td>15</td><td>72</td><td>44</td><td>137</td></tr>
<tr><td>Gynaecological</td><td>13</td><td>15</td><td>8</td><td>1</td><td>37</td></tr>
<tr><td>Haematological</td><td>1</td><td>2</td><td>0</td><td>0</td><td>3</td></tr>
<tr><td>Head and Neck</td><td>16</td><td>27</td><td>6</td><td>4</td><td>53</td></tr>
<tr><td>Lower GI</td><td>3</td><td>6</td><td>6</td><td>1</td><td>16</td></tr>
<tr><td>Lung</td><td>0</td><td>2</td><td>0</td><td>0</td><td>2</td></tr>
<tr><td>Other</td><td>23</td><td>56</td><td>22</td><td>7</td><td>108</td></tr>
<tr><td>Skin</td><td>50</td><td>64</td><td>2</td><td>3</td><td>119</td></tr>
<tr><td>Upper GI</td><td>1</td><td>1</td><td>0</td><td>0</td><td>2</td></tr>
<tr><td>Urological</td><td>5</td><td>9</td><td>40</td><td>60</td><td>114</td></tr>
<tr><td>Total</td><td>118</td><td>197</td><td>156</td><td>120</td><td>591</td></tr>
</table>
</td>
<td>• Cancer Improvement Team have developed Demand & Capacity analysis for first outpatient appointment across most specialties managing suspected cancer referrals; these will be developed into live dashboard views by Informatics with timeframes for this development to be determined.</td>
</tr>
</table>

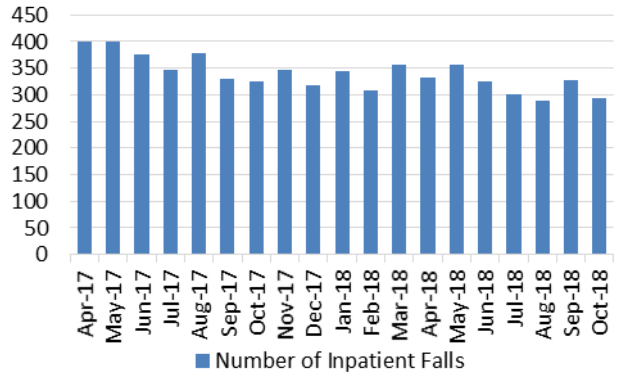
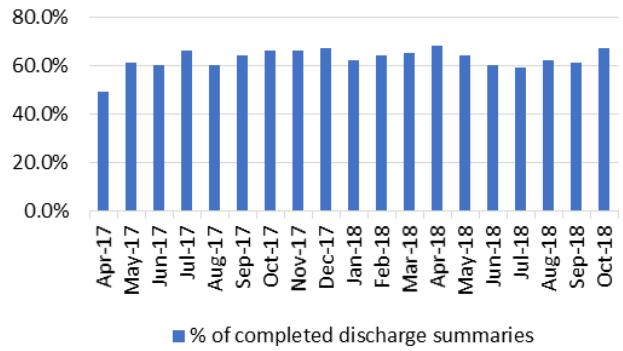
6.1 QUALITY AND SAFETY INDICATORS

This section of the report provides further detail on key quality and safety measures.

Description	Current Performance	Trend	Actions planned for next period
Healthcare Acquired Infections- E.coli bacteraemia- Number of laboratory confirmed E.coli bacteraemia cases	In October 2018, there were 41 cases of *E. coli* bacteraemia. This was 3 fewer cases than the internal profile. 24 cases (56%) were community acquired infections; 17 were hospital acquired infections (MHDU – 8; SHDU – 4; POWHDU – 4; Gorseinon – 1). The cumulative proportion of these cases that are community acquired (67%) are challenging to target with SMART improvement activities. *High bed occupancy is a risk to achieving infection reduction.*	**Number of *healthcare acquired E.coli* bacteraemia cases** 	• During November, Point Prevalence Survey of Peripheral Vascular Catheters and Urinary Catheters in 12 key wards across acute sites to establish baseline prevalence prior to PDSA improvement activities. • Small scale PDSA project on nurse-led removal of urinary catheters to commence in Neath Port Talbot Hospital **by 30.11.18**. • Small scales PDSA pilot of improving quality of mid-stream urine sample collection on two wards to commence **by 30.11.18**.
Healthcare Acquired Infections- S.aureus bacteraemia- Number of laboratory confirmed S.aureus bacteraemias (MRSA & MSSA) cases	In October 2018, there were 12 cases of *Staph. aureus* bacteraemia; 1 case less than the profile. 7 cases were hospital acquired (MH DU – 4; SH DU- 2; POWH DU – 1 including 1 MRSA case). 54% cases, April to the end of October 2018 were community acquired cases; this remains challenging to target with SMART improvement activities. *High bed occupancy is a risk to achieving infection reduction.*	**Number of healthcare acquired S.aureus bacteraemias cases** 	• Delivery Units to continue with focus to increase numbers of staff who have been competence assessed for Aseptic Non Touch Technique (ANTT), with month-on-month improvements by **31.03.2019.** • During November, Point Prevalence Survey of Peripheral Vascular Catheters and Urinary Catheters in 12 key wards across acute sites to establish baseline prevalence prior to PDSA improvement activities. • Haemodialysis unit staff are scoping small scale quality improvement work to commence early **Quarter 3.**

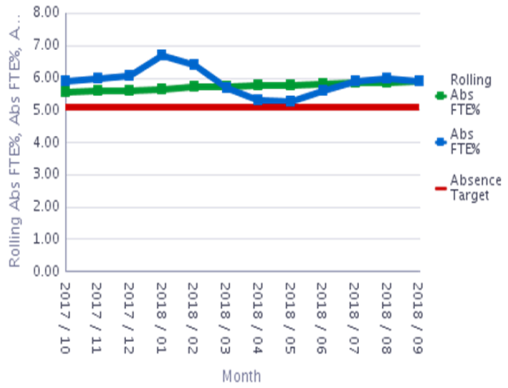
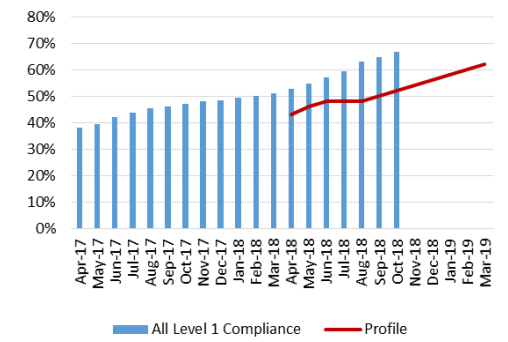
Description	Current Performance	Trend	Actions planned for next period
Healthcare Acquired Infections-C.*difficile*- Number of laboratory confirmed C.difficile cases	In October 2018, there were 19 *Clostridium difficile* toxin positive cases in October. Of these, 15 were hospital acquired (6 in Princess of Wales; 5 in Morriston; and 2 in Singleton). There have been **172 days** since the last hospital acquired *Clostridium difficile* toxin positive case in Neath Port Talbot Hospital. The cumulative position April – October 2018 is approximately 24% below that for the same period in 2017. *High bed occupancy is a risk to achieving infection reduction.* *ABMU continues to be the only Health Board in Wales not to use HPV or UV-C decontamination process.*	**Number of healthcare acquired C.difficile cases** 	• Review compliance with restriction of Co-amoxiclav, with feedback to Delivery Units. **Impact: 50% reduction in annual Co-amoxiclav use by 31.03.19.** • Delivery Units to prioritise High Level Deep Cleaning of source rooms/bays, and plan for proactive '4D' programme: **D**eclutter-**D**ecant–**D**eep clean-**D**isinfect. Service demands and pressures may impede progress during Q3. • Implement weekly C. *diff* ward rounds on two sites initially (dependent of availability of PHW Microbiologist). • Commence small scale quality improvement project relating to improving clinical detail within documented daily reviews– **by 30.11.18.**
Number of Serious Incidents- Number of new Serious Incidents reported to Welsh Government	• The Health Board reported 36 Serious Incidents for the month of October 2018 to Welsh Government. • Last Never Event reported was on 21st March 2018. • In October 2018, the performance against the 80% target of submitting closure forms within 60 working days was 56%.	**Number of Serious Incidents** 	• Trial the new reflective methodology approach to review serious incidents managed by the Serious Incidents (SI) Team. • The SI team are currently in the process of recruiting a Band 7 Concerns & Quality Improvement Manager to work with all Service Delivery Unit's across the Health Board. • The Welsh Risk Pool have suggested that the Pressure Ulcer Improvement methodology be applied to the Falls Improvement work and will coincide with the upcoming relaunch of the Health Board's Fall Prevention and Management Policy.

Description	Current Performance	Trend	Actions planned for next period
30 day response rate for concerns- The percentage of concerns that have received a final reply or an interim reply up to and including 30 working days from the date the concern was first received by the organisation	• The overall Health Board response rate for responding to concerns within 30 working days was 81% in August 2018 against the Welsh Government target of 75% and Health Board target of 80%.	**Response rate for concerns within 30 days** 	• Performance is discussed at all Unit performance meetings. For the first 5 months of this financial year the Health Board has achieved an 80% in responses for the 30 day target. • Two PALS workshops held to review the work undertaken in the Service Delivery units for the PALS teams. Formulation of a PALS Policy and standardised Job Description are the next steps Robust monitoring of the 30 day complaint responses to ensure compliant with Putting Things right Regulations and the contents of the response is valued based. This is undertaken on a monthly audit basis, at a Concerns and Assurance Group meeting with the Units.
Number of pressure ulcers The number of grade 3, 4 suspected deep tissue injury and unstageable pressure ulcers	• The number of Grade 3+ pressure ulcers increased between September and October 2018. The in-patient cases figure deteriorated from 21 in September 2018 to 26 in October 2018, and similarly the number of community cases deteriorated from 22 to 26.	**Total number of grade 3+ hospital and community acquired Pressure Ulcers (PU)** 	• The Pressure Ulcer Prevention Strategic Group received the completed report of 2017-2018 Serious Incident pressure ulcers in October 2018. • Increased focus on the work of scrutiny panels to identify causal factors and support learning to prevent avoidable ulcers. • A report and recommendations from the October pressure ulcer grading audit is being prepared to provide assurance on the accuracy of grading on incident reports and to highlight any training requirements. • The implementation plan for the new Prevention and Management of Pressure Ulcers Policy is in progress.

Description	Current Performance	Trend	Actions planned for next period
Inpatient Falls The total number of inpatient falls	• The number of Falls reported via Datix web reduced from 326 in October 2017 to 293 in October 2018. • The Health Board has agreed a targeted action to reduce Falls causing harm by 10%. • The number of Falls within the Health Board decreased between April 2017 and March 2018 with the number of falls causing harm decreasing by 16%.	**Number of inpatient Falls** 	• Health Board's Falls Policy was ratified by Q&S committee in August 2018. • Training needs analysis ongoing and will form part of the implementation plan of the new policy. • Health Board falls group have cascaded PowerPoint educational training presentation to all delivery units • Unit Nurse Director (POWH) has discussed Falls policy implementation plan at NMB & Health Board Falls group. NMB decision that implementation of policy and Health Board lead for falls will transfer to Unit Nurse Director for NPTH on October 2nd 2018.
Discharge Summaries The percentage of discharge summaries approved and sent to patients' doctor following discharge	• In October 2018 the percentage of electronic discharge summaries signed and sent via eToC was 67% which is 1% more when compared with October 2017. • Performance varies between Service Delivery Units (range was 65% to 84% in October 2018) and between clinical teams within the Units.	**% discharge summaries approved and sent** 	• Performance and improvement actions will continue to be monitored via the Discharge Information Improvement Group (DIIG) • Now that overall signed and sent performance has improved, the focus will be on improving the timeliness of discharge information i.e. Delivery Units' performance in providing discharge information to GPs <24hrs and <5days after discharge. • Unit Medical Directors' are working with CDs and Clinical Leads to address variation between teams • The Health Board is piloting Medicines Transcribing and e-Discharge (MTeD) from August – October 2018

7. WORKFORCE UPDATES AND ACTIONS

This section of the report provides further detail on key workforce measures.

Description	Current Performance	Trend	Actions planned for next period
Staff sickness rates- *Percentage of sickness absence rate of staff*	• The 12 month rolling performance to the end of September 2018 is 5.89% (up 0.03% on August 2018). Our in month performance in Sept 18 was 5.91%, a decrease of 0.07% on the previous month	**% of full time equivalent (FTE) days lost to sickness absence (12 month rolling)** 	• Best Practice report finalised, planned circulation will now take place after R&S committee review. • Pathways guidance has been completed to be issued by end of November 2018. • Improvement Plan completed with targets for reductions in waiting time within OH to be issued following Exec approval (by end Nov 2018). • Flu Champions trained across the health board Winter Flu Immunisation programme underway. • The new all-Wales sickness absence policy has been issued to health boards for implementation. Policy contains both technical changes to the triggers but is also presented in a markedly different way focusing on attendance and wellbeing. The policy comes with a mandated commitment to deliver training over the next 24 months to all managers involved in attendance management. The issues, resources and local arrangements needed to deliver this are currently being assessed. The role of rapid access to OH support is also being considered.
Mandatory & Statutory Training- *Percentage compliance for all completed Level 1 competencies within the Core Skills and Training Framework by organisation*	• October 2018 compliance against the 10 core competencies is 68.28%. This is a 2 % increase from September 2018. This means that over 5,000 competencies completed within a one month period (10,000 since August 2018)	**% of compliance with Core Skills and Training Framework** 	• Highlighted as a risk around resourcing in the paper prepared for Audit Committee. • E-learning drop in sessions at all sites conducted bi-weekly, including staff group specific training undertaken. • Work is continuing on the review of M&S training requirements by role profile to reduce duplication of effort by staff repeating learning already covered at lower levels • Review of Mandatory Framework planned

<table>
<tr><th>Description</th><th>Current Performance</th><th>Trend</th><th>Actions planned for next period</th></tr>
<tr>
<td>Vacancies
Medical and Nursing and Midwifery</td>
<td>

Continue to engage nurses from outside the UK to help mitigate the UK shortage of registered nurses. To date we have in our employ:
EU Nurses employed at Band 5 = 70
Philippine nurses arrived in 17/18 & employed at Band 5 = 30
Regionally organised nurse recruitment days which ensure we are not duplicating efforts across hospital sites. These are heavily advertised across social media platforms via our communications team.
11 Health Care Support Workers (HCSW's) recruited to part time degree in nursing. 7 commenced in Sept-17 on a 4 year programme, the remainder commenced in Jan-18 on a 2 year 9 month programme. We have also secured further external funding to offer similar places to 13 HCSW's in 18/19 and recruitment to these places is underway.
A further 13 of our HCSW's are currently undertaking a 2 year master's programme.

</td>
<td>
Vacancies as at 31st October 2018
<table>
<tr><th>Grade - Medical & Dental</th><th>Budget WTE</th><th>WTE</th><th>(Under) / Over Establishment</th></tr>
<tr><td>Total</td><td>1534.79</td><td>1307.71</td><td>-227.08</td></tr>
<tr><td>21000-Consultant (M&D)</td><td>617.71</td><td>539.33</td><td>-78.38</td></tr>
<tr><td>21100-Locum Consultant (M&D)</td><td>25.56</td><td>34.06</td><td>8.50</td></tr>
<tr><td>22110-Associate Specialist (M&D)</td><td>67.11</td><td>53.43</td><td>-13.69</td></tr>
<tr><td>22200-Locum Associate Specialist (M&D)</td><td>0.00</td><td>0.45</td><td>0.45</td></tr>
<tr><td>22250-Specialist Dental Officer</td><td>3.60</td><td>3.20</td><td>-0.40</td></tr>
<tr><td>22260-Senior Dental Officer</td><td>1.80</td><td>0.00</td><td>-1.80</td></tr>
<tr><td>22270-Dental Officer</td><td>10.22</td><td>7.83</td><td>-2.39</td></tr>
<tr><td>22310-Speciality Doctor (M&D)</td><td>104.64</td><td>77.55</td><td>-27.09</td></tr>
<tr><td>22320-Locum Speciality Doctor (M&D)</td><td>2.10</td><td>1.10</td><td>-1.00</td></tr>
<tr><td>23100-Specialty Registrar (M&D)</td><td>531.31</td><td>411.60</td><td>-119.71</td></tr>
<tr><td>23120-Locum Specialty Registrar (M&D)</td><td>0.50</td><td>21.60</td><td>21.10</td></tr>
<tr><td>23200-Specialist Registrar (M&D)</td><td>6.78</td><td>0.00</td><td>-6.78</td></tr>
<tr><td>23300-Locum Specialist Registrar (M&D)</td><td>1.20</td><td>1.00</td><td>-0.20</td></tr>
<tr><td>24100-F2 foundation year 2 (M&D)</td><td>63.66</td><td>60.69</td><td>-2.97</td></tr>
<tr><td>24110-Locum F2 Foundation year 2 (M&D)</td><td>0.00</td><td>1.00</td><td>1.00</td></tr>
<tr><td>24400-F1 foundation year 1 (M&D)</td><td>80.20</td><td>73.74</td><td>-6.46</td></tr>
<tr><td>24900-Dental Trainees in Hosp.Post</td><td>1.64</td><td>5.60</td><td>3.96</td></tr>
<tr><td>25000-Clinical Assistant (M&D)</td><td>1.37</td><td>0.91</td><td>-0.46</td></tr>
<tr><td>25100-Senior Lecturer (M&D)</td><td>2.90</td><td>1.00</td><td>-1.90</td></tr>
<tr><td>25300-G.P.Sessions / Staff Fund</td><td>12.49</td><td>13.63</td><td>1.14</td></tr>
</table>
<table>
<tr><th>Grade</th><th>Budget WTE</th><th>WTE</th><th>(Under) / Over Establishment</th></tr>
<tr><td>Total</td><td>4894.78</td><td>4526.42</td><td>-368.36</td></tr>
<tr><td>2A182-Nurse Consultant Band 8B</td><td>4.00</td><td>3.69</td><td>-0.31</td></tr>
<tr><td>2A281-Nurse Manager Band 8A</td><td>78.30</td><td>79.80</td><td>1.50</td></tr>
<tr><td>2A282-Nurse Manager Band 8B</td><td>19.80</td><td>27.64</td><td>7.84</td></tr>
<tr><td>2A283-Nurse Manager Band 8C</td><td>12.00</td><td>14.00</td><td>2.00</td></tr>
<tr><td>2A284-Nurse Manager Band 8D</td><td>9.00</td><td>6.00</td><td>-3.00</td></tr>
<tr><td>2A451-Registered Nurse Band 5</td><td>2701.07</td><td>2392.76</td><td>-308.31</td></tr>
<tr><td>2A461-Registered Nurse Band 6</td><td>1246.68</td><td>1221.57</td><td>-25.11</td></tr>
<tr><td>2A471-Registered Nurse Band 7</td><td>767.03</td><td>724.05</td><td>-42.98</td></tr>
<tr><td>2A481-Registered Nurse Band 8A</td><td>52.90</td><td>52.90</td><td>0.00</td></tr>
<tr><td>2A482-Registered Nurse Band 8B</td><td>4.00</td><td>4.00</td><td>0.00</td></tr>
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<td>

Joint Cwm Taf / ABMU recruitment protocol to begin to address boundary change issues is in draft and will be implemented through the period up to transfer.
We are also currently exploring further options of nurses from Dubai and India. We are in the process of preparing a mini tendering exercise which will be aimed at suppliers who are able to provide overseas qualified nurses who already have the requisite English language requirements as this has been the time delay to date in our recruitment timeline.
Work due to commence on the development of a medical recruitment strategy in partnership with the Medical Director/ Deputy Medical Director team.

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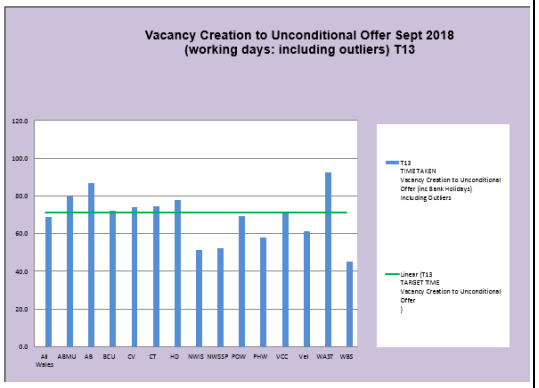
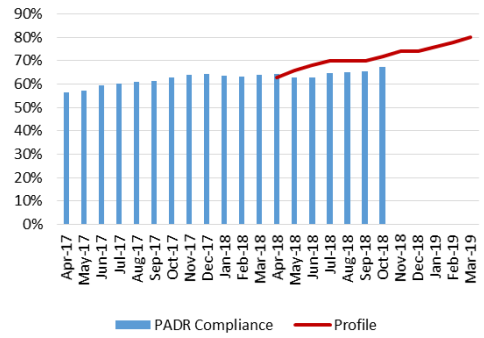
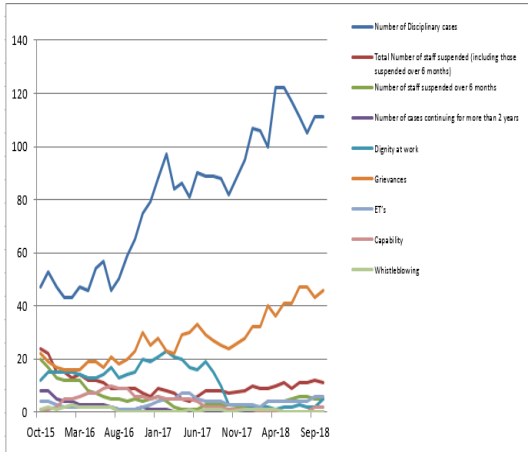
</table>

Description	Current Performance	Trend	Actions planned for next period
Recruitment *Metrics provided by NWSSP. ABMU comparison with All wales benchmarking*	• ABMU overall performance is just above the target level for NHS Wales Internal controls may have contributed to this. • Of the key ABMU measures where we are not yet at target - time to complete sifting has steadily improved towards the three day target and is at seven days.		• Outlier data is passed to Delivery Units for review. • If Outliers (activity well outside the normal expected timescale) are excluded ABMU is well under the 71 day target. Action to sanitise the data will improve accuracy of the reports.
Turnover *% turnover by occupational group*	• Overall Turnover has reduced over the last six months and for the first time is below 8% (FTE) • There has been a steady reduction in Nursing turnover since April 2018. Nurse Turnover is now at the lowest level seen since we recorded data in this format and is below 8% (FTE).	**Period Turnover Rate - 01 November 2017 - 31 October 2018** Staff Group / FTE / Headcount / Change Headcount Add Prof Scientific and Technic 9.42% 9.16% ↑ Additional Clinical Services 7.66% 8.21% ↑ Administrative and Clerical 7.11% 7.49% ↓ Allied Health Professionals 10.09% 10.40% ↓ Estates and Ancillary 5.51% 5.79% ↓ Healthcare Scientists 6.34% 6.82% → Medical and Dental 10.37% 11.34% ↑ Nursing and Midwifery Registered 7.79% 8.18% ↓ **Overall Rate** / FTE / Headcount Overall Rate 7.73% 8.12% ↓	• Roll out of exit interviews across the Health Board following the pilot in Nursing is being looked into as well as the use of ESR exit interview functionality. This is being managed on an all-Wales basis.

Description	Current Performance	Trend	Actions planned for next period
PADR *% staff who have a current PADR review recorded*	• The percentage of staff who have had a Personal Appraisal and Development Review (PADR) in the last 12 months was 67.4% in October 2018: ○ Non-medical staff= 65.1% ○ Medical staff= 93.1%%	**% of staff who have had a PADR in previous 12 months** 	• Focus on training Managers to complete Values Based PADR/use ESR to improve reporting figures. Schedule in place from October 2018 to March 2019 at all sites. • Additionally, bespoke PADR training delivered as requested by teams and units. • Heightened scrutiny process for Delivery Units. • Explore implications of NHS Pay Deal and links with PADR.
Operational Casework *Number of current operational cases by category.*	• Some fluctuation in live cases over the last three months but volume of activity is still significantly increased on averages pre Mid 2016.	**Number of Operational Cases** 	• Procurement issues have been resolved and an order placed for the system. Full implementation expected by Christmas 2018. • Case for investigating officer team 3 x band 6 1 x band 3 was considered by IGB and approved. Recruitment and establishment of team underway with first appointment to the team expected Q4 2018/19. • ACAS supported training looking at improving partnership working and a programme of work with managers to look at bullying and harassment (targeted on hot spots identified in the 2018 staff survey) has been agreed and will begin delivery in Nov/Dec 2018. • A case review exercise is also underway with the support of NWSSP Legal and Risk looking at the most complex and problematic cases.

8. KEY PERFORMANCE MEASURES BY DELIVERY UNIT

8.1 Morriston Delivery Unit- Performance Dashboard

			Quarter 1			Quarter 2			Quarter 3			Quarter 4		
			Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Unscheduled Care	4 hour A&E waits	Actual	63.5%	67.1%	70.0%	70.3%	67.9%	68.8%	70.0%					
		Profile	*71%*	*76%*	*76%*	*83%*	*81%*	*81%*	*85%*	*87%*	*87%*	*86%*	*86%*	*86%*
	12 hour A&E waits	Actual	574	468	333	447	373	311	402					
		Profile	*259*	*124*	*125*	*148*	*168*	*101*	*162*	*206*	*239*	*198*	*143*	*135*
	1 hour ambulance handover	Actual	380	291	245	348	270	261	294					
		Profile	*210*	*79*	*120*	*107*	*171*	*72*	*137*	*177*	*239*	*194*	*139*	*104*
Stroke	Direct admission within 4 hours	Actual	33.9%	33.3%	43.8%	39.6%	29.8%	75.0%	71.7%					
		Profile	*45.0%*	*45.0%*	*45.0%*	*50.0%*	*50.0%*	*50.0%*	*50.0%*	*50.0%*	*50.0%*	*65.0%*	*65.0%*	*65.0%*
	CT scan within 1 hour	Actual	32.3%	44.8%	38.8%	41.7%	36.0%	50.0%	52.5%					
		Profile	*40.0%*	*40.0%*	*40.0%*	*45.0%*	*45.0%*	*45.0%*	*45.0%*	*45.0%*	*45.0%*	*50.0%*	*50.0%*	*50.0%*
	Assessed by Stroke Specialist within 24 hours	Actual	91.9%	100.0%	98.0%	85.4%	92.0%	85.4%	86.9%					
		Profile	*75.0%*	*75.0%*	*75.0%*	*80.0%*	*80.0%*	*80.0%*	*80.0%*	*80.0%*	*80.0%*	*85.0%*	*85.0%*	*85.0%*
	Thrombolysis door to needle within 45 minutes	Actual	0.0%	0.0%	20.0%	27.3%	0.0%	0.0%	11.8%					
		Profile	*20.0%*	*25.0%*	*25.0%*	*30.0%*	*30.0%*	*30.0%*	*35.0%*	*35.0%*	*35.0%*	*40.0%*	*40.0%*	*40.0%*
Planned care	Outpatients waiting more than 26 weeks	Actual	128	101	37	15	31	19	38					
		Profile	*249*	*200*	*150*	*100*	*50*	*0*	*0*	*0*	*0*	*0*	*0*	*0*
	Treatment waits over 36 weeks	Actual	2,379	2,309	2,250	2,285	2,312	2,160	2,179					
		Profile	*2,374*	*2,183*	*2,251*	*2,253*	*2,153*	*1,997*	*1,784*	*1,809*	*1,992*	*1,898*	*1,777*	*1,901*
	Diagnostic waits over 8 weeks	Actual	0	55	0	0	6	0	0					
		Profile	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Cancer	NUSC patients starting treatment in 31 days	Actual	95%	91%	93%	98%	100%	98%	93%					
		Profile	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*
	USC patients starting treatment in 62 days	Actual	75%	100%	90%	98%	94%	91%	93%					
		Profile	*83%*	*85%*	*89%*	*90%*	*91%*	*91%*	*92%*	*92%*	*91%*	*92%*	*92%*	*93%*
Healthcare Acquired Infections	Number of healthcare acquired C.difficile cases	Actual	10	6	6	16	4	2	5					
		Profile	*9*	*5*	*9*	*7*	*7*	*7*	*8*	*9*	*4*	*5*	*4*	*7*
	Number of healthcare acquired S.Aureus Bacteraemia cases	Actual	3	5	5	3	3	3	4					
		Profile	*4*	*5*	*3*	*5*	*4*	*3*	*3*	*2*	*6*	*5*	*5*	*6*
	Number of healthcare acquired E.Coli Bacteraemia cases	Actual	2	3	4	7	5	5	8					
		Profile	*8*	*3*	*6*	*4*	*6*	*4*	*4*	*6*	*7*	*10*	*4*	*5*
Quality & Safety Measures	Discharge Summaries	Actual	63%	58%	59%	53%	61%	59%	66%					
		Profile	*69%*	*72%*	*75%*	*77%*	*80%*	*83%*	*86%*	*89%*	*92%*	*94%*	*97%*	*100%*
	Concerns responded to within 30 days	Actual	93%	83%	90%	87%	84%							
		Profile	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*
Workforce Measures	Sickness rate *(12 month rolling)*	Actual	5.94%	5.94%	5.97%	5.94%	5.98%	6.01%						
		Profile	*5.87%*	*5.79%*	*5.71%*	*5.63%*	*5.55%*	*5.48%*	*5.40%*	*5.32%*	*5.24%*	*5.16%*	*5.08%*	*5.00%*
	Personal Appraisal Development Review	Actual	62%	59%	60%	62%	63%	64%	65%					
		Profile	*63%*	*66%*	*68%*	*70%*	*70%*	*70%*	*72%*	*74%*	*74%*	*76%*	*78%*	*80%*
	Mandatory Training	Actual	50%	52%	55%	57%	60%	61%	62%					
		Profile	*43%*	*46%*	*48%*	*48%*	*48%*	*50%*	*52%*	*54%*	*56%*	*58%*	*60%*	*62%*

Health Board profiles have been utilised in the absence of agreed Unit level profiles using straight line improvement trajectories

8.1 Morriston Delivery Unit- Overview

Successes	Priorities
• Consistently good Cancer Performance. • Significant improvement in Stroke patients with direct admission to an acute stroke unit within 4 hours (average of 38% in Q1 to over 75% in Q2 supported by the front door pilot). • Implementation of the Safety Huddle approach in Morriston, which is a daily meeting that underpins daily hospital operations with a core focus on patient safety and mitigation of risk. • Evaluation of the change in GP expected pathways for surgical patients has shown 72 patients a week now access surgical services directly following referral by their General Practitioner for assessment, treatment or admission rather than via ED. • ED (ECHO) - Well supported junior doctors with consultant leadership on the clinical floor until 11pm daily. • Weekly review of Agency cap breaches by Medical Director and Workforce Group. • Newly qualified Nurses welcomed to Morriston by Unit Nurse Director and senior nursing team at 'meet and greet' event. • Appointment of Quality Improvement Clinical leads. • Infection Control- Significant reduction in all HCA infections. • Staff engagement open day 6th October 2018.	• Delivery of improvement in 4hr ED standard in line with actions in the Q3 action plan. • Winter readiness and use of funding to support assurance & capacity. • Morriston spend in October was £19.4M which is £0.2m above plan. Focus on non-pay and CIP recovery actions. • Flu campaign for front line staff – current uptake is at 50%. • Service Groups to focus on incidents reported since April 2018. • Additional Theatre capacity for pancreatic patients at Singleton. • Implement effective IT system in ED to allow for timely data analysis to evidence what is already being done within the department and support future work-streams. • Reduction in sickness absence. • Awaiting a decision from IBG on Plastics day case facility that will transform the clinical pathway from theatres to day case environment. • Focused improvement on PADR compliance and training within IG and Mandatory training. • Operation and financial plan to deliver the TAVI cases planned in the next quarter. • Delivering high quality patient care and a reduction in waiting times for patients in ED.
Opportunities	**Risks & Threats**
• KPMG have started projects in three key areas – General / Vascular Surgery and Medicine Assessment Unit and #NOF Focussed piece of work with clinical team to be completed in 10 weeks (January 2019). • Cancer - Pathway review of out of area sarcoma patients. • Further outsourcing opportunities to improve Orthopaedic position. • Patient flow recruitment underway linked to release of winter planning monies. Role redesign review of all vacancies at the weekly workforce panel. Review of Sickness Hotspot areas. • On-call manager training sessions planned 22nd November 2018. • Review of ER cases monthly with "Red" ER cases reviewed weekly. • Working with external Consultants to review the ED workforce plan against service demand.	• Theatre staffing/Anaesthetists for the delivery of baseline activity during September and further additional longer term Cardiac RRP to feature. • Nursing and Medical vacancies – recruitment challenges. • Cardiac Surgical theatre staffing challenges impacting on planned activity. Recovery plan in place, Recruitment and Retention Premium supported by NHS Wales to improve recruitment to this key group of staff. • Current ED medical workforce gaps. • Winter.

8.2 Neath Port Talbot Delivery Unit- Performance Dashboard

			Quarter 1			Quarter 2			Quarter 3			Quarter 4		
			Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Unscheduled Care	4 hour A&E waits	Actual	98.4%	96.8%	98.9%	96.9%	99.7%	98.4%	96.8%					
		Profile	*100%*	*100%*	*100%*	*100%*	*100%*	*100%*	*100%*	*100%*	*100%*	*100%*	*100%*	*100%*
	12 hour A&E waits	Actual	0	0	0	0	0	0	0					
		Profile	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Planned care	Outpatients waiting more than 26 weeks	Actual	*0*	*0*	*0*	*0*	*0*	*0*	*0*					
		Profile	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*
	Treatment waits over 36 weeks	Actual	*0*	*0*	*0*	*0*	*0*	*0*	*0*					
		Profile	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*
	Therapy waits over 14 weeks	Actual	*0*	*1*	*0*	*0*	*0*	*0*	*0*					
		Profile	*0*	*0*	*0*		*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Cancer	NUSC patients starting treatment in 31 days	Actual			100%	100%		100%	100%					
		Profile	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*
	USC patients starting treatment in 62 days	Actual	100%	100%	100%	93%	100%	80%	67%					
		Profile	*83%*	*85%*	*89%*	*90%*	*91%*	*91%*	*92%*	*92%*	*91%*	*92%*	*92%*	*93%*
Healthcare Acquired Infections	Number of healthcare acquired C.difficile cases	Actual	4	3	0	0	0	0	0					
		Profile	*0*	*1*	*0*	*0*	*1*	*1*	*1*	*0*	*0*	*2*	*2*	*1*
	Number of healthcare acquired S.Aureus Bacteraemia cases	Actual	0	0	0	0	0	0	0					
		Profile	*0*	*0*	*0*	*1*	*1*	*0*	*1*	*0*	*1*	*1*	*0*	*0*
	Number of healthcare acquired E.Coli Bacteraemia cases	Actual	1	2	2	4	4	0	0					
		Profile	*0*	*2*	*1*	*2*	*1*	*1*	*3*	*1*	*3*	*3*	*1*	*1*
Quality & Safety Measures	Discharge Summaries	Actual	81%	77%	82%	77%	90%	76%	83%					
		Profile	68%	71%	74%	77%	80%	83%	85%	88%	91%	94%	97%	100%
	Concerns responded to within 30 days	Actual	100%	100%	100%	88%	75%							
		Profile	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%
Workforce Measures	Sickness rate *(12 month rolling)*	Actual	5.00%	5.06%	5.24%	5.35%	5.48%	5.48%						
		Profile	5.85%	5.78%	5.70%	5.62%	5.54%	5.47%	5.39%	5.31%	5.23%	5.16%	5.08%	5.00%
	Personal Appraisal Development Review	Actual	72%	69%	68%	72%	70%	70%	77%					
		Profile	63%	66%	68%	70%	70%	70%	72%	74%	74%	76%	78%	80%
	Mandatory Training	Actual	61%	65%	67%	70%	73%	74%	75%					
		Profile	43%	46%	48%	48%	48%	50%	52%	54%	56%	58%	60%	62%

Health Board profiles have been utilised in the absence of agreed Unit level profiles using straight line improvement trajectories

8.2 Neath Port Talbot Delivery Unit- Overview

Successes	Priorities
• Waiting times targets achieved for medical specialties and therapies • 96% complaints response within 30 working days. • No C. *difficile* infections since bioquel. • Recruitment of another RMO, vacancies now down to 2 • RDC – increased referrals accepted YTD, 228 patient seen, 22 diagnoses of cancer. • RDC – recurrent business case accepted at IBG now out to recruit permanent staff • Maintaining performance of reduced number of falls causing harm. • Award of Bevan Health Technology Exemplar for 2nd successive year. • ESD 14 patients admitted – 8 from acute sites, 5 discharges, good outcomes excellent patient feedback none requiring Packages of Care • OT HCSW framework - successful rollout across HB and completion by staff	• Support staff and services through boundary changes. • Develop primary care services for therapies. • Increase triage staffing in MIU to meet 99% 4hr target. • Consultant Antimicrobial Pharmacist and Antimicrobial Stewardship. • MHRA licence for Singleton PTS and replacement air handling plant for Morriston PTS. • Recruitment of Registered Nurses. • Expand ESD Team to early evening to increase support. • Support the development and establishment of a stroke ESD service. • Increasing elective surgical activity. • Secure agency therapists to support winter plans. Establish extended hours within Pharmacy and support Winter pressures. • Support Plas Bryn Rhosyn Winter Plan to alleviate pressures within wards. • Secure agency physiotherapist to support MSK waiting times. • Develop the Research & Development agenda and digital mobilisation.
Opportunities	**Risks & Threats**
• Strategic Review of MIU, Afan Nedd and rheumatology infusion unit, linking with Singleton Unit re chemotherapy infusions • Remodelling of therapy management and financial structures to one structure enabling timely responsive and good clinical governance for service developments • Centralisation of booking office for medical specialties – recruitment in progress. • Further development of pharmacy specialty teams to support inpatients and specialist clinics. • Develop primary care OT posts to address the preventative and early intervention needs of our population • Develop R&D within OT /physio/ N&D to support clinically effective service delivery for our patients • Re-structure of primary care pharmacy team (due to staff loss) to support long term work agenda & pharmacy contract with PCCS. • Work with our communities to develop sustainable solutions to well-being by developing social enterprise opportunities • Development of long term posts in therapies and pharmacy to support winter plans in a sustainable format.	• Capacity within the Community for discharges. • Relatively low number of training technician posts and therefore capacity for new technician role expansion. Loss of pharmacists to cluster & practice based roles. • Increased workload from NICE / New Treatment Fund appraisals. • Nurse recruitment challenges. • Bridgend boundary changes. • WFI WHSCC activity challenges obtaining donors • Devolved management and financial therapy budgets leads to governance issues and the reduces ability of therapy services to remodel, flex and respond to patients/ service needs • Brexit – increased equipment costs • WFI WHSCC activity underperforming • MIU staffing pressures • Lack of AP in Morriston for Medical Gas testing. • Ward refurbishments and demands for Medical Gases exceed resource available.

8.3 Princess of Wales Delivery Unit- Performance Dashboard

			Quarter 1			Quarter 2			Quarter 3			Quarter 4		
			Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Unscheduled Care	4 hour A&E waits	Actual	75.4%	81.1%	82.6%	80.1%	76.9%	74.5%	76.2%					
		Profile	*85%*	*85%*	*85%*	*88%*	*88%*	*88%*	*88%*	*88%*	*88%*	*88%*	*88%*	*88%*
	12 hour A&E waits	Actual	163	155	141	141	136	274	275					
		Profile	*63*	*68*	*49*	*78*	*57*	*77*	*92*	*109*	*49*	*85*	*53*	*43*
	1 hour ambulance handover	Actual	101	130	88	61	90	227	253					
		Profile	*38*	*34*	*26*	*40*	*42*	*58*	*68*	*81*	*35*	*55*	*41*	*28*
Stroke	Direct admission within 4 hours	Actual	42.1%	34.4%	33.3%	33.3%	28.6%	21.8%	25.8%					
		Profile	*45%*	*45%*	*45%*	*50%*	*50%*	*50%*	*50%*	*50%*	*50%*	*65%*	*65%*	*65%*
	CT scan within 1 hour	Actual	47.4%	40.6%	74.1%	37.5%	48.3%	43.8%	53.1%					
		Profile	*40%*	*40%*	*40%*	*45%*	*45%*	*45%*	*45%*	*45%*	*45%*	*50%*	*50%*	*50%*
	Assessed by Stroke Specialist within 24 hours	Actual	76.3%	75.0%	70.4%	70.8%	89.7%	43.8%	75.0%					
		Profile	*75%*	*75%*	*75%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*85%*	*85%*	*85%*
	Thrombolysis door to needle within 45 minutes	Actual	0.0%	16.7%	66.7%	0.0%	0.0%	25.0%	40.0%					
		Profile	*20%*	*25%*	*25%*	*30%*	*30%*	*30%*	*35%*	*35%*	*35%*	*40%*	*40%*	*40%*
Planned care	Outpatients waiting more than 26 weeks	Actual	31	15	17	12	2	15	21					
		Profile	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*
	Treatment waits over 36 weeks	Actual	1,003	1,026	1,038	1,077	1,175	1,191	1,159					
		Profile	*1,059*	*1,150*	*1,073*	*1,028*	*1,122*	*1,070*	*989*	*900*	*1,053*	*956*	*845*	*763*
	Diagnostic waits over 8 weeks	Actual	23	111	254	90	143	127	116					
		Profile	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Cancer	NUSC patients starting treatment in 31 days	Actual	89%	91%	93%	100%	96%	94%	94%					
		Profile	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*
	USC patients starting treatment in 62 days	Actual	75%	82%	76%	85%	88%	78%	76%					
		Profile	*83%*	*85%*	*89%*	*90%*	*91%*	*91%*	*92%*	*92%*	*91%*	*92%*	*92%*	*93%*
Healthcare Acquired Infections	Number of healthcare acquired C.difficile cases	Actual	3	2	1	2	2	2	6					
		Profile	*6*	*5*	*4*	*8*	*6*	*6*	*5*	*4*	*2*	*4*	*3*	*3*
	Number of healthcare acquired S.Aureus Bacteraemia cases	Actual	3	1	1	3	2	2	1					
		Profile	*1*	*3*	*0*	*2*	*0*	*1*	*1*	*1*	*2*	*1*	*1*	*1*
	Number of healthcare acquired E.Coli Bacteraemia cases	Actual	3	4	2	2	4	3	4					
		Profile	*1*	*2*	*2*	*3*	*2*	*3*	*3*	*5*	*4*	*3*	*1*	*3*
Quality & Safety Measures	Discharge Summaries	Actual	72%	64%	60%	64%	68%	59%	65%					
		Profile	*55%*	*59%*	*63%*	*67%*	*71%*	*76%*	*80%*	*84%*	*88%*	*92%*	*96%*	*100%*
	Concerns responded to within 30 days	Actual	75%	90%	64%	90%	88%							
		Profile	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*
Workforce Measures	Sickness rate *(12 month rolling)*	Actual	5.23%	5.18%	5.25%	5.25%	5.26%	5.30%						
		Profile			*5.20%*			*5.15%*			*5.08%*			*5.00%*
	Personal Appraisal Development Review	Actual	61%	59%	58%	60%	61%	63%	68%					
		Profile	*63%*	*66%*	*68%*	*70%*	*70%*	*70%*	*72%*	*74%*	*74%*	*76%*	*78%*	*80%*
	Mandatory Training	Actual	52%	54%	55%	58%	63%	66%	68%					
		Profile	*43%*	*46%*	*48%*	*48%*	*48%*	*50%*	*52%*	*54%*	*56%*	*58%*	*60%*	*62%*

Health Board profiles have been utilised in the absence of agreed Unit level profiles using straight line improvement trajectories

8.3 Princess of Wales Delivery Unit- Overview

Successes	Priorities
• Commence cardiac CT at POWH 16th October to assist the Health Board & region. • Recruitment of locum respiratory consultant to assist with winter respiratory pressures – individual also interested in supporting the acute oncology service • Acute Oncology Service (Macmillan) Clinical Nurse Specialist commenced in October and service launched. • Shortlisted a suitable candidate for substantive consultant Radiologist post.	• Develop IMTP for POWH Unit services as part of the Cwm Taf planning cycle • Finalise General Medicine Consultant on call arrangements • Improve 4 hours stroke performance (October slight improvement on September but still low) • Implement action plan to achieve 85% PADR compliance by 31/03/19. • Radiology Consultant and Sonographer recruitment to vacant posts. • Progressing project plan for ITU refurbishment, consideration of PACU on the back of the Health Minister announced £15m recurring fund. • Implement outcome of Patient Flow Management Consultation • Develop and implement robust winter planning arrangements • Review of POWH escalation processes including review of surge capacity areas on site.
Opportunities	**Risks & Threats**
• Further opportunities to assist with Cardiac diagnostics and catheter lab activity in POWH • Continued resilience on tackling theatre safety and theatre efficiencies through reduction of cancellations on the day, and reducing late starts and early finishes. • Potential to implement WPAS system into the POWH ED to replace Accent/PDM – aim for February 2019	• Recent possible scope decontamination issues • Risks to financial position with no reduction in POWH spend to cover NPT radiology slots and Urology on call still in place • Consultant sick leave from Swansea Radiologists who perform Ultrasound scans at NPTH losing a large number of patient slots in August, September, October and going into November. • Increasing ED demand for majors and increasing minors attendances (seasonal) is resulting in unprecedented levels of attendances in addition to the acuity and complexity of patients arriving at ED by ambulance is increasing. • Impact of additional paediatric workload as per modelling of change of flows within Cwm Taf.

8.4 Singleton Delivery Unit- Performance Dashboard

			Quarter 1			Quarter 2			Quarter 3			Quarter 4		
			Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Unscheduled Care	4 hour A&E waits	Actual	99.8%	99.7%	99.5%	98.7%	99.2%	98.5%	98.1%					
		Profile	*99.0%*	*99.0%*	*99.0%*	*99.0%*	*99.0%*	*99.0%*	*99.0%*	*99.0%*	*99.0%*	*99.0%*	*99.0%*	*99.0%*
	12 hour A&E waits	Actual	0	1	2	2	2	3	3					
		Profile	*1*	*2*	*5*	*3*	*2*	*2*	*1*	*0*	*0*	*0*	*0*	*1*
	1 hour ambulance handover	Actual	45	31	18	34	60	38	43					
		Profile	*8*	*12*	*6*	*12*	*16*	*19*	*17*	*4*	*31*	*13*	*4*	*8*
Planned care	Outpatients waiting more than 26 weeks	Actual	*6*	*4*	*1*	*3*	*72*	*55*	*6*					
		Profile	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*
	Treatment waits over 36 weeks	Actual	*16*	*14*	*31*	*21*	*10*	*30*	*32*					
		Profile	*24*	*23*	*1*	*3*	*12*	*0*	*0*	*0*	*0*	*0*	*0*	*0*
	Diagnostic waits over 8 weeks	Actual	*0*	*0*	*0*	*0*	*0*	*0*	*0*					
		Profile	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Cancer	NUSC patients starting treatment in 31 days	Actual	93%	89%	100%	100%	97%	96%	96%					
		Profile	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*
	USC patients starting treatment in 62 days	Actual	83%	89%	84%	92%	100%	83%	84%					
		Profile	*83%*	*85%*	*89%*	*90%*	*91%*	*91%*	*92%*	*92%*	*91%*	*92%*	*92%*	*93%*
Healthcare Acquired Infections	Number of healthcare acquired C.difficile cases	Actual	2	1	3	5	1	1	4					
		Profile	*3*	*0*	*4*	*3*	*3*	*3*	*2*	*8*	*3*	*3*	*3*	*3*
	Number of healthcare acquired S.Aureus Bacteraemia cases	Actual	0	2	1	2	4	2	2					
		Profile	*2*	*0*	*1*	*3*	*1*	*3*	*1*	*1*	*2*	*0*	*1*	*1*
	Number of healthcare acquired E.Coli Bacteraemia cases	Actual	3	4	1	7	3	5	4					
		Profile	*6*	*4*	*4*	*4*	*5*	*4*	*4*	*4*	*2*	*1*	*1*	*3*
Quality & Safety Measures	Discharge Summaries	Actual	73%	72%	61%	67%	61%	62%	69%					
		Profile	*73%*	*76%*	*78%*	*81%*	*83%*	*86%*	*88%*	*90%*	*93%*	*95%*	*98%*	*100%*
	Concerns responded to within 30 days	Actual	60%	65%	88%	83%	94%							
		Profile	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*
Workforce Measures	Sickness rate *(12 month rolling)*	Actual	5.73%	5.79%	5.91%	5.95%	6.04%	6.13%						
		Profile	*5.56%*	*5.51%*	*5.46%*	*5.41%*	*5.36%*	*5.31%*	*5.25%*	*5.20%*	*5.15%*	*5.10%*	*5.05%*	*5.00%*
	Personal Appraisal Development Review	Actual	58%	60%	59%	62%	63%	64%	64%					
		Profile	*63%*	*66%*	*68%*	*70%*	*70%*	*70%*	*72%*	*74%*	*74%*	*76%*	*78%*	*80%*
	Mandatory Training	Actual	49%	50%	53%	55%	60%	62%	65%					
		Profile	*43%*	*46%*	*48%*	*48%*	*48%*	*50%*	*52%*	*54%*	*56%*	*58%*	*60%*	*62%*

Health Board profiles have been utilised in the absence of agreed Unit level profiles using straight line improvement trajectories

8.4 Singleton Delivery Unit- Overview

Successes	Priorities
• Achievement of no patients waiting over 8 weeks for an Endoscopy procedure. • Continued achievement of RTT 26, 36 and 52 week target for all medical specialties in Q2 2018/19. • Selection to be part of the UKAS pilot for medical equipment service management. Date set to January 15-17th 2019. • New mobile DEXA machine unveiled on 9 November 2018. • Participation in Swansea University's Science Festival on 8th November demonstrating technology and raising awareness to the public.	• Manage RTT pressures in Ophthalmology and Gynaecology following recent workforce challenges. • Service Resign: Redesign Services Ward 4&7 and embedding ICOPS model. • Integrated workforce planning. • IMTP. • Develop a plan to support Radiotherapies waiting times. • Transfer of 2 x neonatal cots from POWH. • Improvement in PADR and Mandatory training compliance across all disciplines.
Opportunities	**Risks & Threats**
• Identify potential saving through review of contracts. • SARC – interim model agreed. • Hywel Dda service changes. • Increase neonatal capacity at Singleton to increase income Role of non medical prescribers (CNS, pharmacists). • Appointment of PA in rotation with medicine and GP for next year. • Expansion of the role of the AOS nurses. • Delivery Unit to support Health Board case for Nerve centre implementation. • Review Endoscopy capacity and Demand and agree strategic direction. • Provision of radiopharmaceuticals to Withybush Hospital. Welsh Wound Innovation Centre (WWIC) –plans to endorse PUPIS pressure ulcer training to roll out to Wales.	• Cwm Taf Boundary Remapping. • Cladding. • New treatment Fund / Introduction of new drugs- Limited capacity in Chemotherapy Day Unit for delivery of infusion therapies. • Pressures on front door. • Availability of Staff. • Under delivery of Waterfall elements. • Lack of funding for medical equipment means that more equipment is being used beyond a reasonable life expectancy. • A No Deal Brexit may impact of the availability medical equipment, spares, consumables etc. This will delay repairs. • Radiotherapy CT has had end of support notification for 31-12-2018. • Notes storage – child health/HYM/NPT Childrens centres. • Inadequate ward facilities for acute paediatrics at Morriston

8.5 Mental Health & Learning Disabilities Performance Dashboard

			Quarter 1			Quarter 2			Quarter 3			Quarter 4		
			Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Mental Health Measures *(excluding CAMHS)*	% MH assessments undertaken within 28 days	Actual	90%	94%	91%	93%	93%	90%						
		Profile	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*
	% therapeutic interventions started within 28 days	Actual	83%	81%	80%	84%	90%	93%						
		Profile	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*
	% of qualifying patients who had 1st contact with an Independent MH Advocacy (IMHA)	Actual			100%			100%						
		Profile			*100%*			*100%*			*100%*			*100%*
	% of residents in receipt of secondary MH services who have valid care and treatment plan (CTP)	Actual	90%	90%	88%	88%	90%	91%						
		Profile	*90%*	*90%*	*90%*	*90%*	*90%*	*90%*	*90%*	*90%*	*90%*	*90%*	*90%*	*90%*
	Residents assessed under part 3 of MH measure sent a copy of their outcome assessment report within 10 working days of assessment	Actual	100%	100%	100%	100%	100%	100%						
		Profile	*100%*	*100%*	*100%*	*100%*	*100%*	*100%*	*100%*	*100%*	*100%*	*100%*	*100%*	*100%*
Healthcare Acquired Infections	Number of healthcare acquired C.difficile cases	Actual	1	1	0	0	0	0	0					
		Profile	*0*	*1*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*
	Number of healthcare acquired S.Aureus Bacteraemia cases	Actual	0	0	0	0	0	0	0					
		Profile	*0*	*0*	*0*	*1*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*
	Number of healthcare acquired E.Coli Bacteraemia cases	Actual	1	1	0	0	0	1	0					
		Profile	*0*	*0*	*0*	*1*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Quality & Safety Measures	Discharge Summaries completed and sent	Actual	74%	71%	81%	85%	86%	88%	84%					
		Profile	*77%*	*79%*	*81%*	*83%*	*85%*	*88%*	*90%*	*92%*	*94%*	*96%*	*98%*	*100%*
	Concerns responded to within 30 days	Actual	71%	100%	100%	83%	100%							
		Profile	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*
Workforce Measures	Sickness rate *(12 month rolling)*	Actual	6.07%	6.11%	6.11%	6.05%	5.98%	6.02%						
		Profile			*6.03%*			*5.93%*			*5.83%*			*5.73%*
	Personal Appraisal Development Review	Actual	85%	77%	79%	77%	74%	77%	79%					
		Profile			*80%*			*83%*			*85%*			*85%*
	Mandatory Training *(all staff- ESR data)*	Actual	64%	66%	68%	69%	70%	72%	73%					
		Profile			*60%*			*70%*			*80%*			*85%*

Health Board profiles have been utilised in the absence of agreed Unit level profiles using straight line improvement trajectories

8.5 Mental Health & Learning Disabilities Delivery Unit- Overview

Successes	Priorities
• The Delivery Unit regularly meets all requirements of sections 1,3 and 4 of the Mental Health Measure. Section 2 is being managed closely to ensure the small dips experienced in June and July are avoided in the future. • Maintaining low number of healthcare acquired infections, with each occurrence reviewed for lessons learnt. • Maintaining relatively high levels of compliance with the PADR measures.	• Ongoing intervention with frequent areas of poor compliance. Awareness on importance of timely discharge summaries with all Clinical Staff. • Recruitment and retention of staff for critical nursing and medical vacancies. • Hold and improve current rate of sickness through, Staff Health & Wellbeing Action Plan 18/19; Pilot Delivery Unit Staff Counsellor; Pilot Performing Medicine Staff Wellbeing programme; Promote Well Being Champions roles (47). • Improving Information Governance Training performance.
Opportunities	**Risks & Threats**
• Leads from Strategy continue to progress discussions with Cwm Taf towards the improvement of the CAMHS element of the Mental Health Measure. • Mandatory training has improved however, Localities are working to improve this further towards compliance. • Terms of reference for the serious incident group have been updated and the format of the reports has been changed in line with the recommendations from the Delivery Unit report to be in line with the rest of the Health Board. A learning matrix has been developed to embed and share the learning identified from serious incidents. RCA Training needs to be provided for investigators. • A new system for supporting performance on complaints has been put in place with weekly reviews by the Q&S team lead by the Head of Operations to support the localities to respond within the 30 day time scale.	• Capacity gaps in Care Homes. Capacity and fragility of private domiciliary care providers, leading to an increase in the number of patients in hospital who are 'discharge fit' and increasing length of stay. • Recruitment market for substantive nursing and medical vacancies. • Security issues in Cefn Coed and Garngoch Hospitals.

8.6 Primary Care & Community Services Delivery Unit- Performance Dashboard

			Quarter 1			Quarter 2			Quarter 3			Quarter 4		
			Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Planned Care	*Outpatients waiting more than 26 weeks*	Actual	*1*	*0*	*0*	*0*	*0*	*0*	*0*					
		Profile	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*
	Treatment waits over 36 weeks	Actual	*0*	*0*	*0*	*0*	*0*	*0*	*0*					
		Profile	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*
	Therapy waits over 14 weeks	Actual	*0*	*0*	*0*	*0*	*0*	*0*	*0*					
		Profile	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Primary Care Access Measures	% of GP practices open during daily core hours or within 1 hour of daily core hours	Actual	94%	94%	94%	94%	90%	95%						
		Profile	*95%*	*95%*	*95%*	*95%*	*95%*	*95%*	*95%*	*95%*	*95%*	*95%*	*95%*	*95%*
	% of GP practices offering daily appointments between 17:00 and 18:30	Actual	82%	82%	82%	84%	78%	88%						
		Profile	*95%*	*95%*	*95%*	*95%*	*95%*	*95%*	*95%*	*95%*	*95%*	*95%*	*95%*	*95%*
	% population regularly accessing NHS primary dental care- 2 year rolling position	Actual			62.5%									
		Profile												
Healthcare Acquired Infections	Clostridium Difficile cases (Community acquired)	Actual	6	5	5	5	7	4	4					
		Profile	*3*	*6*	*9*	*2*	*5*	*3*	*3*	*3*	*3*	*5*	*3*	*6*
	Clostridium Difficile cases (Community Hospitals)	Actual	0	0	0	1	1	0	0					
		Profile	*0*	*0*	*0*	*0*	*0*	*0*	*1*	*0*	*1*	*0*	*0*	*1*
	Staph.Aueurs bacteraemia cases - (Community acquired)	Actual	8	13	12	9	11	3	5					
		Profile	*6*	*10*	*9*	*6*	*4*	*5*	*7*	*11*	*10*	*6*	*12*	*7*
	Staph.Aueurs bacteraemia cases - (Community Hospitals)	Actual	0	0	0	0	0	0	0					
		Profile	*0*	*0*	*0*	*0*	*1*	*1*	*0*	*0*	*0*	*0*	*0*	*0*
	E.Coli cases (Community acquired)	Actual	32	28	31	31	30	34	24					
		Profile	*30*	*28*	*27*	*31*	*28*	*33*	*30*	*21*	*25*	*28*	*32*	*30*
	E.Coli cases (Community Hospitals)	Actual	0	1	1	0	0	1	1					
		Profile	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Quality & Safety	Concerns responded to within 30 days	Actual	57%	63%	63%	55%	38%							
		Profile	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*
Workforce Measures	Sickness rate *(12 month rolling)*	Actual	5.76%	5.71%	5.73%	5.74%	5.68%	5.68%						
		Profile	*5.72%*	*5.66%*	*5.59%*	*5.53%*	*5.46%*	*5.40%*	*5.33%*	*5.26%*	*5.20%*	*5.13%*	*5.07%*	*5.00%*
	Personal Appraisal Development Review	Actual	80%	80%	79%	78%	78%	76%	77%					
		Profile	*63%*	*66%*	*68%*	*70%*	*70%*	*70%*	*72%*	*74%*	*74%*	*76%*	*78%*	*80%*
	Mandatory Training	Actual	60%	62%	64%	67%	69%	72%	75%					
		Profile	*43%*	*46%*	*48%*	*48%*	*48%*	*50%*	*52%*	*54%*	*56%*	*58%*	*60%*	*62%*

Health Board profiles have been utilised in the absence of agreed Unit level profiles using straight line improvement trajectories

8.6 Primary Care & Community Services Delivery Unit- Overview

Successes	Priorities
• ABMU Community staff selected to receive Patient Choice Awards • New pathway successfully implemented for home termination of pregnancies via the Sexual Health Service • Common Ailment Service now commissioned in 100% of Community Pharmacies – 3,276 consultations delivered to date • Successful recruitment of 3 further Practices to join the second wave of Dental Contract Reform Programme • Confirmation of 1st wave Transformation funding to develop a Whole System cluster transformation model in Cwmtawe cluster and request form Welsh Government to submit a further proposal to roll out across all 8 clusters • Cluster Lead presented on the collaborative work between Bay Health Cluster and the Balanced Lives Programme at the House of Commons hosted by Tonia Antoniazzi MP for Gower. • Respiratory nurse COPD Pulmonary Rehab Team Bridgend is a finalist in the Welsh Nurse of the Year competition • Dental Practice Advisor with ABMU has been invited to present to the National Primary Care Conference on 15 November. • Business Justification Cases have been submitted to WG for the refurbishment of Penclawdd & Murton community clinics	• Working with Morriston Unit to implement a reduction in length of stay in the recommissioned 8 beds in Gorseinon Hospital • Agreeing Winter Planning arrangements to assist with patient flow over the Christmas period • Engagement commenced re closure of Maesteg Day Hospital • Roll-out of Mobilisation project to Swansea Community teams following successful roll-out across NPT • Community Flu champions commenced vaccination programme of staff - Community staff working with GP practices to ensure at risk groups across the ABMU population are vaccinated • Support needed for proposed new Dental Practice by engagement with NPT CBC to lift existing covenant on building • Plan the implementation of Urgent Paeds pathway for Dental GA service from Dec 18 • Prepare for a follow up public meeting with the Cymmer community which has been proposed for 19th December • To scale our Whole System cluster transformation across the 8 cluster footprint. • Submission of Strategic Outline Case for the Swansea Wellness centre and WCCIS Business case to IBG 20th November
Opportunities	**Risks & Threats**
• Smarter way of working around phlebotomy via the introduction and roll-out of Point of Care testing • Further work to be carried out with WAST to enhance skill mix of Urgent Primary Care Team by securing Paramedic and Nurse practitioner input via SLA • Work with Morriston Hospital Unit colleagues to develop new oral medicine pathway for urgent suspected oral cancers • The Health Board launched a new initiative to improve the sustainability of dental services this month, introducing a General Dental Practitioner [GDP] Fellowship scheme; a three year scheme to train a Fellow in Endodontics to work in primary care.	• Overall impact of Bridgend Boundary change • Continued staffing shortages within Bridgend District Nursing • Continue to progress and implement contingency plans to minimise risk of RTT breaches in Restorative Dentistry • Engagement with Primary and Secondary clinicians on incoming e-referral process for planned implementation from November • Potential continued negative engagement from Cymmer population. • Alternative options have been sought to house Murton and Penclawdd surgeries to allow services to continue nearby. • Potential transfer of Croeserw Comm. Centre from Council management – request to consider relocating Cymmer Health Centre

9. QUARTERLY PERFORMANCE REPORT CARDS

9.1 Staying Healthy

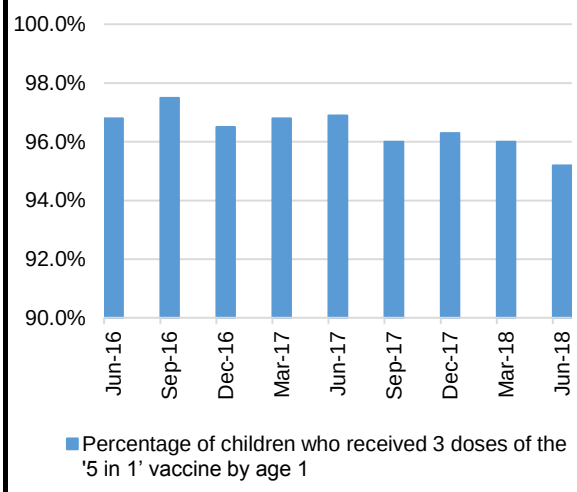
STAYING HEALTHY - PEOPLE IN WALES ARE WELL INFORMED AND SUPPORTED TO MANAGE THEIR OWN PHYSICAL AND MENTAL HEALTH

Measure 1: % of children who received 3 doses of the '5 in 1' vaccine by age 1
Measure 2: % of children who received 2 doses of the MMR vaccine by age 5

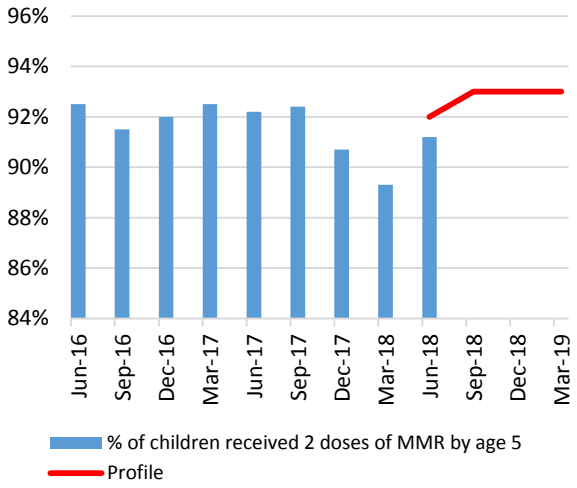
Corporate Objective : Promoting & Enabling Healthier Communities			**Executive Lead :** Sandra Husbands Director of Public Health	
Outcome Statement : My children have a good healthy start in life				
Period : June 18	**IMTP Profile Target :**	**WG Target :** 95%	**Current Status :** ✕	**Movement :** ↓ ● Worsening

Current Trend: Jun 16 - Jun 18

(1) % of children who received 3 doses of the '5 in 1' vaccine by age 1

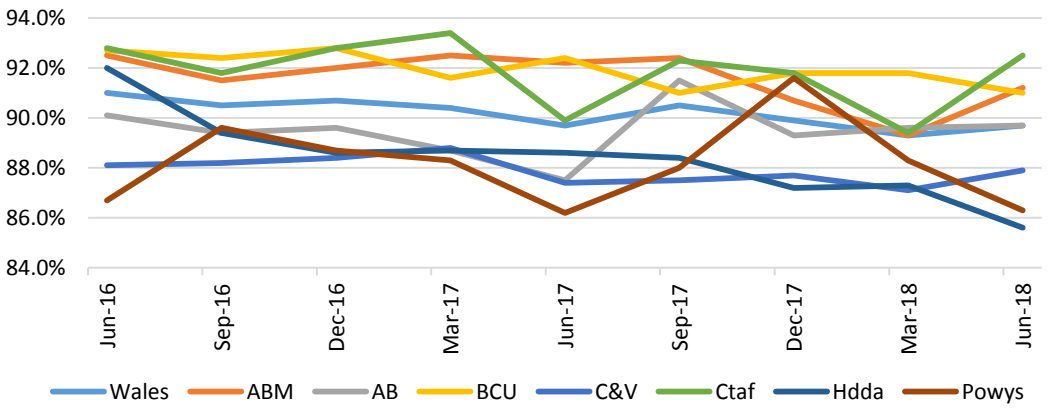


(2) % of children who received 2 doses of the MMR vaccine by age 5



Benchmarking

(2) % of children who received 2 doses of the MMR vaccine by age 5



Source : Vaccine Uptake in Children in Wales April to June 2018 (COVER 127)

Measure 1: % of children who received 3 doses of the '5 in 1' vaccine by age 1
Measure 2: % of children who received 2 doses of the MMR vaccine by age 5

How are we doing?

- Measure 1 – Although during this quarter there is a slight decrease in the percentage of children who have received 3 doses of the 5 in 1 by 1yr of age, we continue to achieve the Welsh Government target of 95%. Two Local Authority areas are however below 95% during the reporting quarter, both at 94.6%

- Measure 2 – during this reporting quarter there has been an increase in the percentage of children who have received 2 doses of the MMR vaccine by age 5, although ABMU remain below the 95% target needed for herd immunity.

What actions are we taking?

- The current waiting lists and the number of cancelled immunisation clinics are being monitored by the primary care team, with a new reporting mechanism in place for further discussion in the Strategic Immunisation Group (SIG). Following a recent SIG meeting, a task and finish group will be arranged to ensure we continue to see a reduction in the number of children on waiting lists, whilst also ensuring the number of cancelled clinics are reducing across the health board. In addition the task and finish group will ensure the reporting mechanism in place is consistent across the three Local Authority areas.
- Children who were reported as having outstanding immunisations for this quarterly report were followed up by the named Health Visitor. Child Health records were amended for those children that had either already received the vaccine or had moved out of area. Opportunistic vaccination has been encouraged amongst across the Health Board.
- As recommended by the internal audit a business case will be developed for additional resource to perform routine data cleansing to ensure data held on the Child Health Information System is the same as that on GP records. This will improve confidence in the COVER data, whilst enabling health care professionals to target areas with low uptake rates.

What are the main areas of risk?

- During this reporting quarter we are below 95% in the number of children who have received 2 doses of the MMR by 5 years which is needed for herd immunity.

- When uptake is below 95% the main area of risk is an outbreak of measles, which has occurred within two Health Boards in south east Wales over the past few months.

How do we compare with our peers?

- Measure 1 – ABMU is ranked 5th in comparison to the other Welsh Health Boards and below the Welsh average of 95.5%

- Measure 2 – ABMU is ranked 2nd in comparison to the other Welsh Health Boards and above the Welsh average of 89.7%

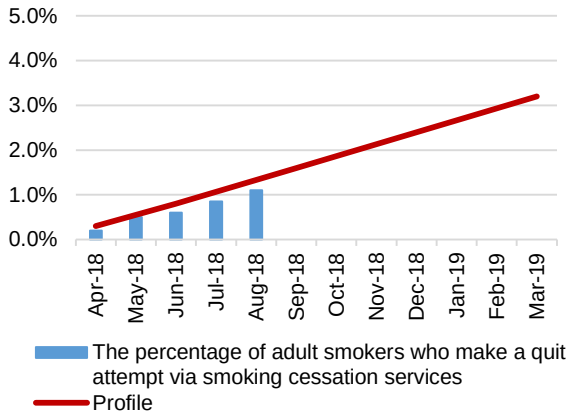
STAGING HEALTHY - PEOPLE IN WALES ARE WELL INFORMED AND SUPPORTED TO MANAGE THEIR OWN PHYSICAL AND MENTAL HEALTH

Measure 1: % Welsh resident smokers make a quit attempt via Smoking Cessation Services (numerator = set a quit date each month; denominator derived from ABMU smoking population)
Measure 2: % Welsh resident smokers who are CO validated as successfully quitting at 4 weeks (people previously setting a quit date and now quit)

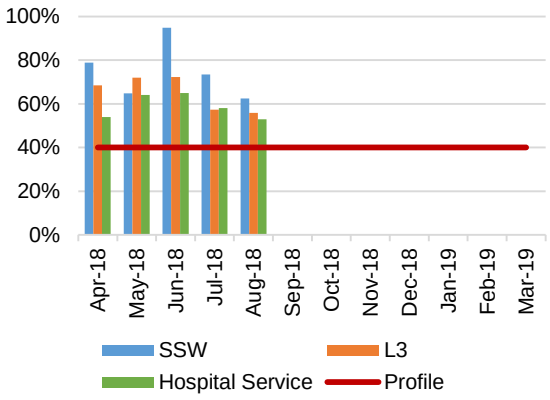
Corporate Objective : Promoting & Enabling Healthier Communities			**Executive Lead :** Sandra Husbands Director of Public Health	
Outcome Statement : I am healthy and active and do the things to keep myself healthy				
Period : August 18	**IMTP Profile Target :** (1) 1.34% (2) 40%	**WG Target :** (1) 5% (2) 40%	**Current Status :** ✗	**Movement :** ↑ ● Improving

Current Trend: 2018 - 2019 (monthly)

(1) % Welsh resident smokers make a quit attempt via Smoking Cessation Services



(2) % Welsh resident smokers who are CO validated as successfully quitting at 4 weeks



Benchmarking

(1) % Welsh resident smokers make a quit attempt via Smoking Cessation Services

LHB	Current Q1-Q4 17/18	Previous Q1-Q4 16/17
Wales	3.1%	↑ 2.1%
ABM	2.6%	↑ 1.8%
AB	3.5%	↑ 2.0%
BCU	3.8%	↑ 2.9%
C&V	1.7%	↑ 1.0%
CTaf	4.6%	↑ 2.9%
HDda	2.7%	↑ 1.6%
Powys	2.2%	↑ 1.6%

(2) % Welsh resident smokers who are Co validated as successfully quitting at 4 weeks

LHB	Current Q1-Q4 17/18	Previous Q1-Q4 16/17
Wales	43.0%	↑ 40.9%
ABM	54.8%	↑ 50.7%
AB	40.1%	↓ 41.1%
BCU	32.4%	↑ 30.2%
C&V	60.3%	↑ 56.3%
CTaf	36.9%	↓ 37.6%
HDda	55.6%	↓ 56.9%
Powys	44.4%	↓ 47.3%

Source : NHS WALES OUTCOMES FRAMEWORK, ALL WALES PERFORMANCE SUMMARY (October 2018)

Measure 1: % Welsh resident smokers make a quit attempt via Smoking Cessation Services (numerator = set a quit date each month; denominator derived from ABMU smoking population)
Measure 2: % Welsh resident smokers who are CO validated as successfully quitting at 4 weeks (people previously setting a quit date and now quit)

How are we doing?

- To achieve the 5% smoking cessation target approximately 4,711 smokers need to be treated in ABMU stop smoking services per year, with an average of 393 smokers treated per month. A target of 3.2% has been set for the ABM UHB Annual Plan. To achieve this 3.2% target, approximately 3015 smokers need to be treated in ABM stop smoking services per year, with an average of 251 smokers treated per month. ABMU has treated 1003 smokers (monthly activity data) against the cumulative monthly target of 1,255, achieving to August 2018 1.1% of the overall target. This is higher than the figure to August 2017 at 905 or 1%.
- All three smoking cessation services are exceeding the 40% target for CO Validated 4 week quitters.
- The most recent data from the National Survey for Wales 2016/17 estimates that 21% of ABMU's population (aged 16+) smoke. This is higher than the all-Wales average of 19%.

What actions are we taking?

- ABMU Cessation Services Steering group established to aid greater collaborative working and collective planning between ABMU cessation services.
- National integrated cessation system in progress. ABMU services involved and supportive.
- Development of minimum service standards on all Wales basis.
- 100 Community Pharmacies commissioned from April 2018 to deliver the level 3 smoking cessation service. The Primary Care Pharmacy Service have a plan in place to address performance and share success of top performing Pharmacies.
- A Service review of the in house hospital based service has been completed and recommendations around management of service are being taken forward.
- Maternal smoking priority as part of Welsh Government National improvement programme. National monthly meetings held, looking at system wide improvements across Health Boards. ABMU maternal smoking working group established. Work progressing to understand the needs of pregnant smokers and improve attrition in cessation services including development of a cessation pathway, training for all Midwives to support conversations and pilot with Maternity Support Workers.

What are the main areas of risk?

- New cessation brand ‘Help me quit’ introduced in 2018. Possible confusion for smokers and service referrers during transition period.
- Focus currently on cessation services and driving the demand to services, without addressing the broader supportive environments and wider determinants agenda.
- The demand for ABMU cessation services from smokers does not produce the required number of treated smokers.
- Commissioned pharmacies are now accredited, but not all are actively delivering the service.
- Inpatient referrals to the in house hospital service remain low despite a high level of training and awareness raising about service.
- Smoking on hospital grounds continues to be a widespread issue and visible problem despite Health Board smoke free site policy.

How do we compare with our peers?

- The latest published data available from Welsh Government shows that for quarter 1 18/19, ABMU was above the all-Wales position for the percentage of resident smokers who are CO validated as successfully quitting at 4 weeks, and below the all-Wales position for the percentage of resident smokers making a quit attempt via smoking cessation services.
- ABMU has improved performance for the percentage of resident smokers who are CO Validated as quitting at 4 weeks compared to the previous year.

9.2 Safe Care

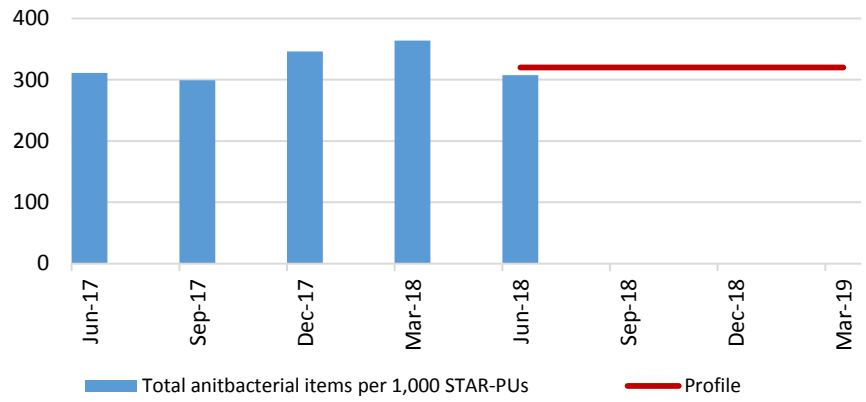
SAFE CARE - PEOPLE IN WALES ARE PROTECTED FROM HARM AND SUPPORTED TO PROTECT THEMSELVES FROM KNOWN HARM

Measure 1: Total antibacterial items per 1,000 STAR-PUs (specific therapeutic group age related prescribing unit)

Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access				**Executive Lead :** Gareth Howells Director of Nursing & Patient Experience
Outcome Statement : I am safe and protected from harm through high quality care, treatment and support				
Period : June 2018	**IMTP Profile Target :** 320	**WG Target :** 4 quarter reduction trend	**Current Status :** ✗	**Movement :** ↑ ● Worsening

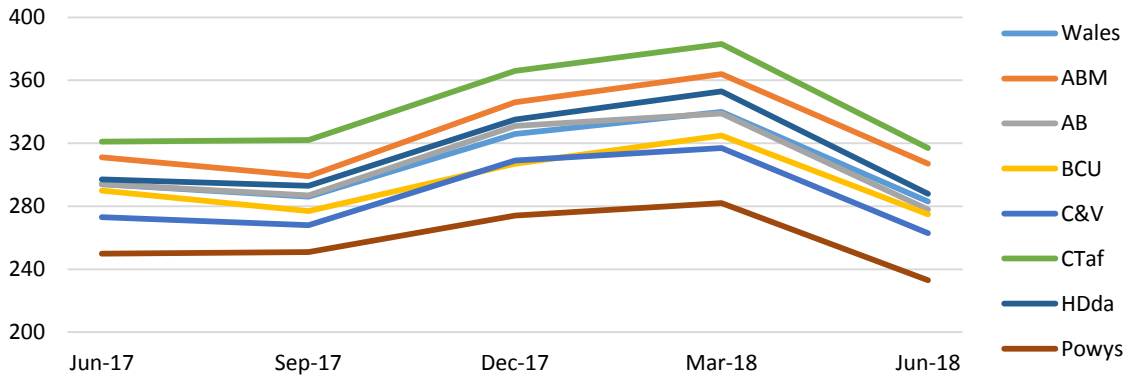
Current Trend: Jun 17 – Jun 18

(1) Total antibacterial items per 1,000 STAR-PUs (specific therapeutic group age related prescribing unit)



Benchmarking

(1) Total antibacterial items per 1,000 STAR-PUs (specific therapeutic group age related prescribing



Source : NHS WALES OUTCOMES FRAMEWORK, ALL WALES PERFORMANCE SUMMARY (October 2018)

Measure 1: Total antibacterial items per 1,000 STAR-PUs (specific therapeutic group age related prescribing unit)

How are we doing?

- While the long term trend is down, there has been some slowing and reversal that requires close monitoring.

What actions are we taking?

To maintain focus and build on the legacy of the ABMU Big Fight Campaign, the following are in place:

- Included in the 2018-19 Prescribing Management Scheme including a co-amoxiclav audit
- Highlighted in every practice's annual prescribing visit
- Supported additional audits in target practices
- Regular guideline updates
- Regular updates via prescribing leads meetings including presentation from microbiologist
- Highlighting links and resources to national campaigns
- Links with Primary Care & Community Services work with care homes and other projects

What are the main areas of risk?

- The main risk is to maintain and build on progress made. Any increases could increase risk of resistance and C.Difficile.

How do we compare with our peers?

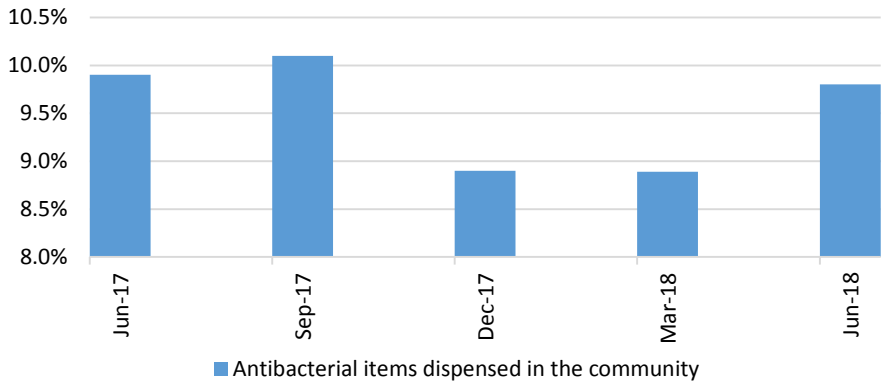
- ABMU had shown significant progress over the last 2-3 years and is no longer the highest in Wales. However, there is still much to do to continue to improve appropriate prescribing.

SAFE CARE - PEOPLE IN WALES ARE PROTECTED FROM HARM AND SUPPORTED TO PROTECT THEMSELVES FROM KNOWN HARM

Measure 1: Fluroquinolone, cephalosoporin, clinamycin and co-amoxiclav items as a percentage of total antibacterial items dispensed in the community

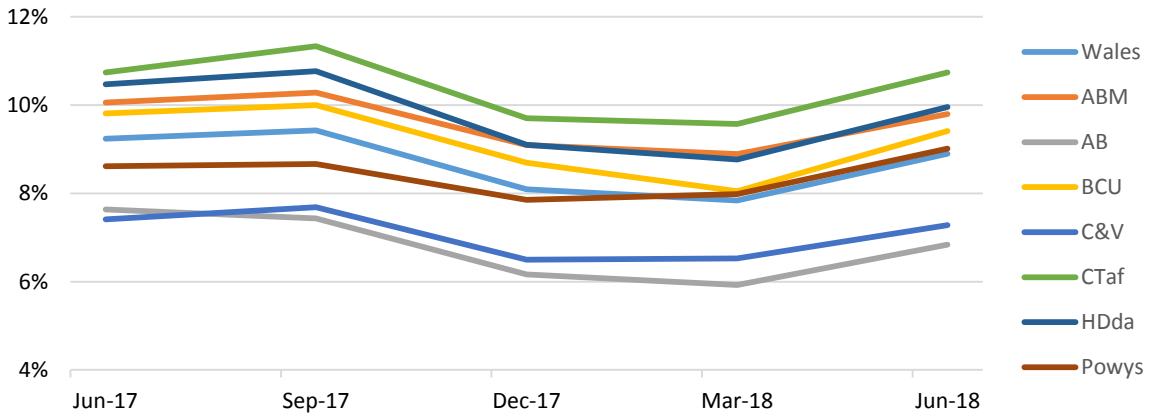
Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			**Executive Lead :** Gareth Howells Director of Nursing & Patient Experience	
Outcome Statement : I am safe and protected from harm through high quality care, treatment and support				
Period : June 2018	**IMTP Profile Target:**	**WG Target :** Quarter on quarter improvement	**Current Status :** ✓	**Movement :** ↓ ● Improving
Current Trend: Jun 17 - Jun 18				

(1) Fluroquinolone, cephalosoporin, clinamycin and co-amoxiclav items as a percentage of total antibacterial items dispensed in the community



Benchmarking

(1) Fluroquinolone, cephalosoporin, clinamycin and co-amoxiclav items as a percentage of total antibacterial items dispensed in the community



Source : NHS WALES OUTCOMES FRAMEWORK, ALL WALES PERFORMANCE SUMMARY (October 2018)

Measure 1: Fluroquinolone, cephalosoporin, clinamycin and co-amoxiclav items as a percentage of total antibacterial items dispensed in the community

How are we doing?

- After an initial significant reduction 2-3 years ago, these antibiotics have shown some increases, which are being monitored and targeted.

What actions are we taking?

To maintain focus, the following are in place:

- Included in the 2018-19 Prescribing Management Scheme (overall prescribing and a co-moxiclav audit)
- Highlighted in every practice's annual prescribing visit
- Supported additional audits in target practices
- Regular guideline updates
- Regular updates via prescribing leads meetings including updates from microbiologists
- Significant changes in co-amoxiclav use in acute will also impact on primary care prescribing culture

What are the main areas of risk?

- The main risk is to maintain and build on progress made. Any increases could increase risk of resistance and C.Difficile.

How do we compare with our peers?

- ABMU's performance needs to show further improvements as we are above the Welsh average.

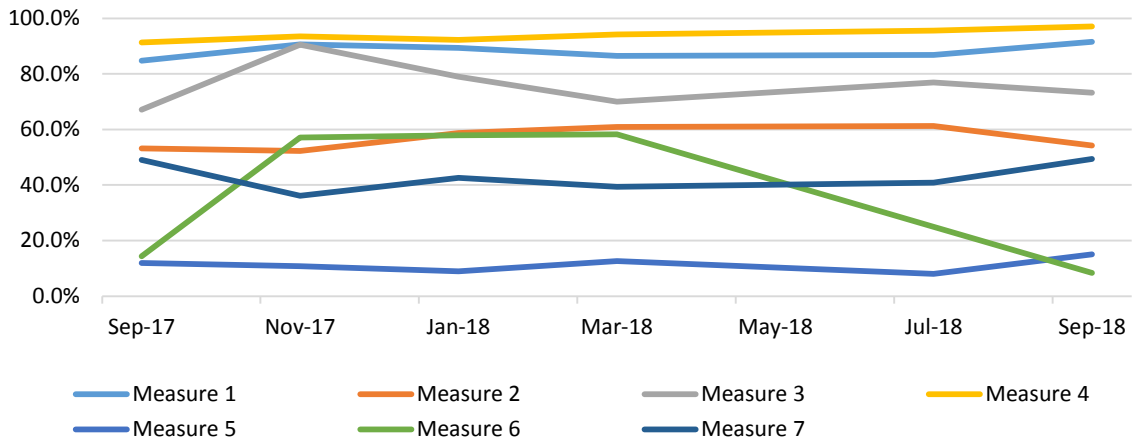
SAFE CARE - PEOPLE IN WALES ARE PROTECTED FROM HARM AND SUPPORTED TO PROTECT THEMSELVES FROM KNOWN HARM

Measure 1: % indication for antibiotic documented on medication chart, Measure 2: % stop or review date documented in medication chart, Measure 3: % of antibiotics prescribed on stickers, Measure 4: % appropriate antibiotic prescriptions choice, Measure 5: % of patients receiving antibiotics for more than 7 days, Measure 6: % of patients receiving surgical prophylaxis for more than 24 hours, Measure 7: % of patients receiving IV antibiotics > 72 hours

Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			**Executive Lead :** Gareth Howells Director of Nursing & Patient Experience	
Period : September 2018	**IMTP Profile Target :**	**Local Target :** (1) >95% (2) >95% (3) >95% (4) >95% (5) ≤20% (6) ≤20% (7) ≤30%	**Current Status :** ✗	**Movement :** → Stable

Current Trend: Sep 17 - Sep 18

% compliance with Antimicrobial Audits (HB Total)



Sep-18	POWH	Morriston	Singleton	NPTH	MH & LD	HB Total
(1) % indication for antibiotic documented on medication chart	95.3%	93.6%	83.5%	100.0%	93.3%	91.5%
(2) % stop or review date documented on medication chart	45.1%	48.5%	63.1%	100.0%	100.0%	54.2%
(3) % of antibiotics prescribed on stickers	-	0.0%	75.0%	88.9%	66.7%	73.2%
(4) % appropriate antibiotic prescriptions choice	100.0%	97.8%	92.1%	100.0%	100.0%	97.0%
(5) % of patients receiving antibiotics for more than 7 days	15.2%	19.3%	10.8%	7.1%	0.0%	15.1%
(6) % of patients receiving surgical prophylaxis for more than 24 hours	0.0%	25.0%	-	0.0%	-	8.3%
(7) % of patients receiving IV antibiotics > 72 hours	51.3%	57.5%	39.1%	0.0%	-	49.4%

Source : ABMU Pharmacy

Measure 1: % indication for antibiotic documented on medication chart, Measure 2: % stop or review date documented in medication chart, Measure 3: % of antibiotics prescribed on stickers, Measure 4: % appropriate antibiotic prescriptions choice, Measure 5: % of patients receiving antibiotics for more than 7 days, Measure 6: % of patients receiving surgical prophylaxis for more than 24 hours, Measure 7: % of patients receiving IV antibiotics > 72 hours

How are we doing?

- The new restrictive guidelines launched in June 2018, which promote more use of narrow spectrum antibiotics. Excellent compliance to the new guidelines continues to be observed and systems are in place to tackle episodes of non-compliance via co-amoxiclav authorisation forms and pharmacist exception reporting to the unit medical directors.
- Compliance with documentation of indications is also approaching target but documentation stop/review dates needs improvement.
- We continue to see a high proportion of patients remaining on IV antibiotics for longer than the recommended 48 - 72 hour period. An early switch to oral antibiotics has numerous benefits including removal of lines and expediting early discharge.
- Surgical prophylaxis over 24 hours has decreased which shows improved compliance with the single dose recommended in the antibiotic guidelines for the majority of procedures.

What actions are we taking?

- A planned rollout of the Public Health Wales “Start Smart the Focus audits”, which will be doctor led audit, is being progressed by the Health Board Antimicrobial stewardship Group. This audit will raise awareness amongst junior doctors of the principles of SSTF 48 – 72 hour review which includes early IV to oral switch. Consultant champions within each speciality are being recruited to co-ordinate junior staff.
- Guideline work has begun with Burns and Plastics to further reduce our co-amoxiclav usage within the Health Board.
- Antibiotic Quality Improvement Projects are being undertaken by junior doctors in a number of sites.

What are the main areas of risk?

- We are awaiting a replacement clinician chair for the Antibiotic stewardship Group, this group is pivotal to ensure the successful introduction of the doctor-led audits.

How do we compare with our peers?

- No national data available for comparison.

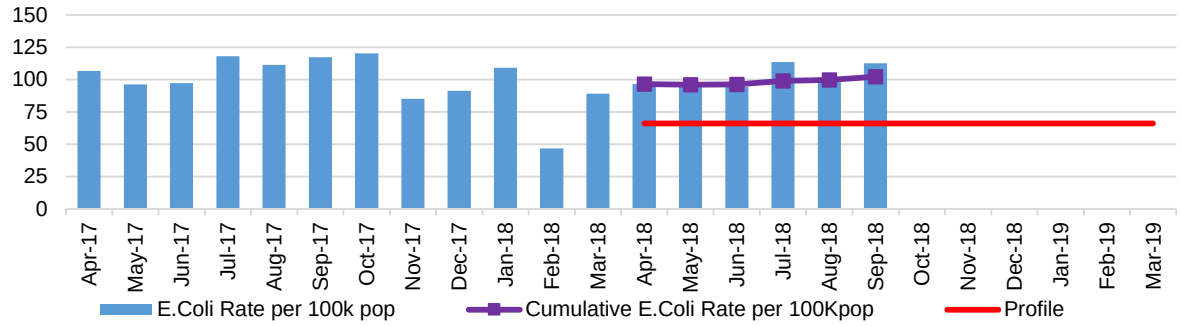
SAFE CARE - PEOPLE IN WALES ARE PROTECTED FROM HARM AND SUPPORTED TO PROTECT THEMSELVES FROM KNOWN HARM

Measure 1: Number of cases of E. coli bacteraemia per 100,000 of the population
Measure 2: Number of E.coli cases
Measure 3: Number of cumulative cases of E. coli bacteraemia against March 2019 reduction expectation

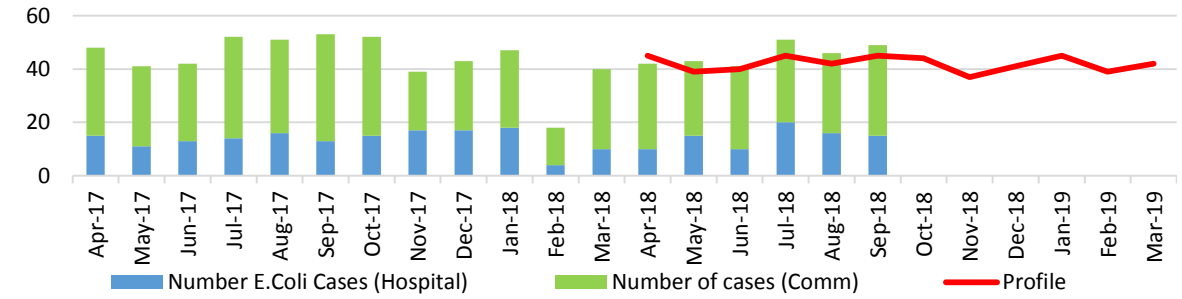
Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			**Executive Lead :** Gareth Howells Director of Nursing & Patient Experience	
Outcome Statement : I am safe and protected from harm through high quality care, treatment and support				
Period : September 2018	**IMTP Profile Target :** (2) 45	**WG Target :** (1) <26 (3) 177	**Current Status :** ✗	**Movement :** ↑ ● Worsening

Current Trend: Sep 17 - Sep 18

(1) Rate of E.coli bacteraemia per 100,000 of the population.



(2) Number of E.coli bacteraemia cases



Benchmarking

(3) Number of cumulative cases of E. coli bacteraemia against March 2019 reduction expectation

LHB	Cumulative Cases (Apr - Sep 18)	Max cumulative cases to achieve Mar-19 reduction expectation	Variance
Wales	1319	1042	+277
ABM	271	177	+94
AB	239	178	+61
BCU	283	232	+51
C&V	188	146	+42
Ctaf	147	99	+48
Hdda	185	128	+57

Source : Public Health Wales: C. difficile, S. aureus and E.coli bacteraemia monthly dashboard (September 2018)

Measure 1: Number of cases of E. coli bacteraemia per 100,000 of the population
Measure 2: Number of E.coli cases
Measure 3: Number of cumulative cases of E. coli bacteraemia against March 2019 reduction expectation

How are we doing?

- In September 2018, the Health Board's total number of *E. coli* bacteraemia cases was 49 cases. This was 4 cases more than the IMTP profile for September 2018.
- Of the 49 cases, 34 (69%) were community acquired infections; 15 (31%) were hospital acquired infections. Of the 15 hospital acquired cases, there were 5 cases associated with Morriston Hospital Delivery Unit (DU); 5 cases associated with Singleton Hospital; 3 cases associated with Princess of Wales Hospital; Glanrhyd Hospital (Mental Health) and Maesteg Hospitals (community) each had one hospital acquired case.
- To the end of September 2018, 19, (42%) of the 2018/19 cumulative cases of *E. coli* bacteraemia had a probable urinary source and 19% of these were associated with urinary catheters. Identifying the probable source of *E. coli* bacteraemia is key to developing focussed Quality Improvement programmes.
- The cumulative position to 30 September was 272, 16 cases above the cumulative trajectory profile, but approx. 5% fewer cases than in the same period in 2017/18.

What actions are we taking?

- Delivery Units (DU) are to focus on improving compliance with the number of staff that have completed Aseptic Non Touch Technique (ANTT) training - 10% improvement on staff trained by 31 March 2019.
- It is possible now to record ANTT competence on ESR; the accuracy of this system is dependent on Delivery Units sending lists of staff to the member of staff that can update ESR.
- During first month in post (October 2018), IPC Quality Improvement (QI) Matron will meet with Delivery Units to scope out QI PDSA programmes being undertaken and identify opportunities for shared learning and improvement.
- IPC Team to undertake Point Prevalence Survey of invasive device use in 6 hot spot wards, and compare against incidence identified in the 2017 PPS - by 31.10.2018. The 2018 prevalence will be used as a baseline prior to implementation of PDSA improvement methodologies.

What are the main areas of risk?

- A large proportion of *E. coli* bacteraemia is community acquired, with many patient related contributory factors, particularly in relation to urinary tract infection and biliary tract disease. As such, it will be a challenge to prevent a significant proportion of these.

How do we compare with our peers?

- In September 2018, ABMU had the highest incidence of *E.coli* bacteraemia in comparison with the other major Welsh Health Boards.
- To the end of September 2018, ABMU had the highest cumulative incidence of *E.coli* bacteraemia in comparison with the other Welsh Health Boards.

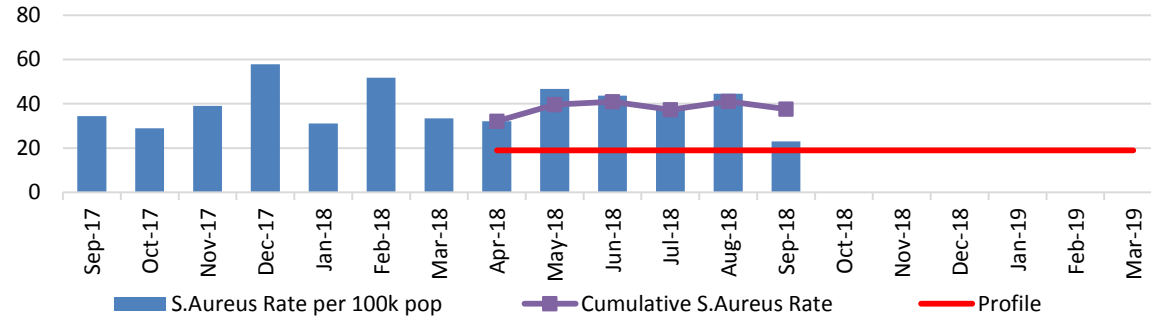
SAFE CARE - PEOPLE IN WALES ARE PROTECTED FROM HARM AND SUPPORTED TO PROTECT THEMSELVES FROM KNOWN HARM

Measure 1: Number of cases of S. aureus bacteraemia per 100,000 of the population
Measure 2: Number of S. aureus bacteraemia cases
Measure 3: Number of cumulative cases of S. aureus bacteraemia against March 2019 reduction expectation

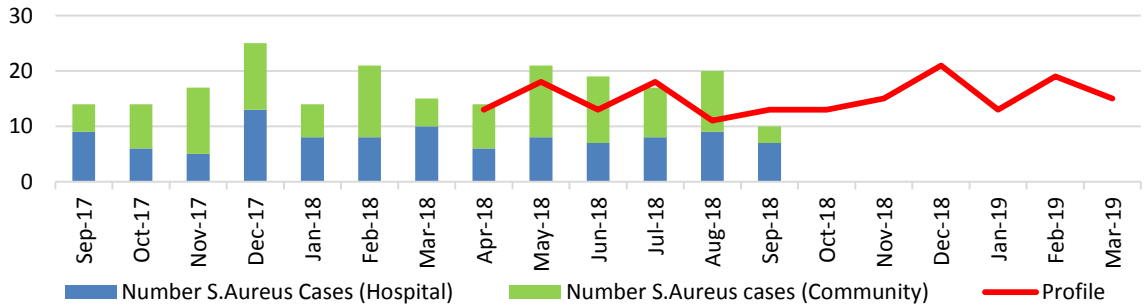
Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			**Executive Lead :** Gareth Howells Director of Nursing & Patient Experience	
Outcome Statement : I am safe and protected from harm through high quality care, treatment and support				
Period : September 2018	**IMTP Profile Target :** (2) 13	**WG Target :** (1) <20 (3) 52	**Current** Status : ✓	**Movement :** ↓ Improving

Current Trend: Sep 17 - Sep 18

(1) Rate of S.*aureus* bacteraemia per 100,000 of the population



(2) Number of S.*aureus* cases



Benchmarking

(2) Number of cumulative cases of S.*aureus* bacteraemia against March 2019 reduction expectation

LHB	Cumulative Cases (Apr - Sep 18)	Max cumulative cases to achieve Mar-19 reduction expectation	Variance
Wales	454	311	+143
ABM	100	52	+48
AB	78	55	+23
BCU	83	69	+14
C&V	79	48	+31
Ctaf	51	29	+22
Hdda	62	37	+25

Source: Public Health Wales C.difficile, S.aureus and E.coli bacteraemia monthly dashboard (September 18)

Measure 1: Number of cases of S. aureus bacteraemia per 100,000 of the population
Measure 2: Number of S. aureus bacteraemia cases
Measure 3: Number of cumulative cases of S. aureus bacteraemia against March 2019 reduction expectation

How are we doing?

- In September 2018, the Health Board's total number of cases was 10, this was 3 cases below the IMTP profile.
- Of the 10 cases, 7 (70%) were hospital acquired infections; 3 (30%) were community acquired infections. Morriston Hospital accounted for 43% of the hospital acquired cases; Princess of Wales and Singleton Hospitals each accounted for 29% of hospital acquired cases. There was one case of MRSA bacteraemia, which was hospital acquired.
- There were 5 fewer cases of *Staph. aureus* bacteraemia in September 2018 compared with September 2017.
- The cumulative position, April to September 2018, is 7% higher than the cumulative position for the same period in 2017. 55% cumulative cases to the end of September 2018 were community acquired cases; this remains a challenge for targeted interventions.

What actions are we taking?

- Delivery Units (DU) are to focus on improving compliance with the number of staff that have completed Aseptic Non Touch Technique (ANTT) training - 10% improvement on staff trained by 31 March 2019.
- It is possible now to record ANTT competence on ESR; the accuracy of this system is dependent on Delivery Units sending lists of staff to the member of staff that can update ESR.
- During first month in post (October 2018), IPC Quality Improvement (QI) Matron will meet with Delivery Units to scope out QI PDSA programmes being undertaken and identify opportunities for shared learning and improvement.
- IPC Team to undertake Point Prevalence Survey of invasive device use in 6 hot spot wards, and compare against incidence identified in the 2017 PPS - by 31.10.2018. The 2018 prevalence will be used as a baseline prior to implementation of PDSA improvement methodologies.

What are the main areas of risk?

- 55% of *Staph. aureus* bacteraemia is community acquired, with many patient related contributory factors, such as recreational drug use, arthritis, chronic conditions, etc. As such, it is a challenge to prevent a significant proportion of these.
- Current increased use of pre-emptive beds on acute sites increases risks of infection transmission.
- Bed occupancy, which frequently is close to, or exceeds, 90%. Analysis by the Department of Health, reported in Tackling Healthcare associated infections through effective policy action (BMA, June 2009), suggested that when all other variables are constant, an NHS organisation with an occupancy rate above 90 per cent could expect a 10.3% higher MRSA rate compared with an organisation with an occupancy levels below 85%.
- High bed turnover. In the same BMA report, the impact on MRSA rates of turnover intervals were suggested to have a greater impact on MRSA rates than bed occupancy levels.

How do we compare with our peers?

- In September 2018, ABMU had the second lowest incidence of Staph. *aureus* bacteraemia in comparison with the other major Welsh Health Boards.
- To date in 2018/19 ABMU has the highest cumulative incidence of Staph. *aureus* bacteraemia in comparison with the other Welsh Health Boards.

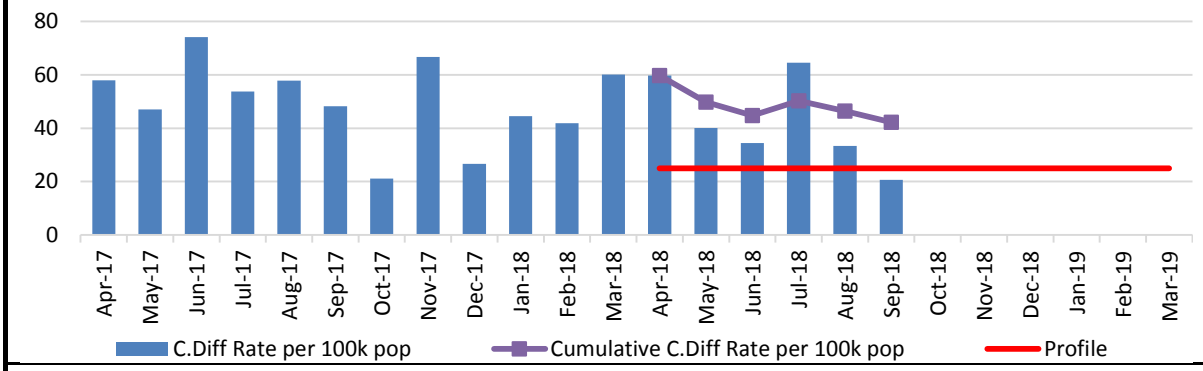
SAFE CARE - PEOPLE IN WALES ARE PROTECTED FROM HARM AND SUPPORTED TO PROTECT THEMSELVES FROM KNOWN HARM

Measure 1: Rate of C.*difficile* cases per 100,00 of the population
Measure 2: Number of C.*difficile* cases
Measure 3: Number of cumulative cases of C.*difficile* against March 2019 reduction expectation

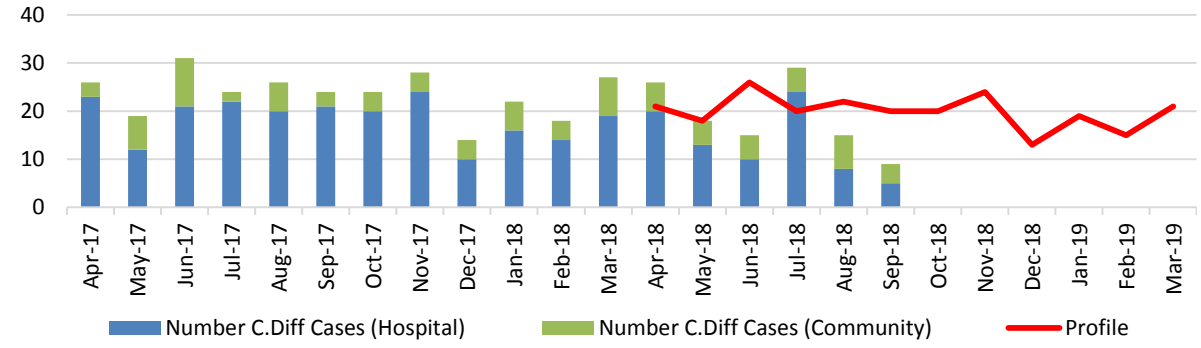
Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			**Executive Lead :** Gareth Howells Director of Nursing & Patient Experience	
Outcome Statement : I am safe and protected from harm through high quality care, treatment and support				
Period : September 2018	**IMTP Profile Target :** (2) 26	**WG Target :** (1) <26 (3) 68	**Current Status :** ✓	**Movement :** ↓ ● Improving

Current Trend: Sep 17 - Sep 18

(1) Rate of C.d*ifficile cases* per 100,000 of the population.



(2) Number of C.d*ifficile cases*



Benchmarking

(3) Number of cumulative cases of C.*difficile* against March 2019 reduction expectation

LHB	Cumulative Cases (Apr - Sep 18)	Max cumulative cases to achieve Mar-19 reduction expectation	Variance
Wales	479	404	+75
ABM	112	68	+44
AB	75	73	+2
BCU	96	90	+6
C&V	62	55	+7
Ctaf	34	26	+8
Hdda	89	49	+40

Source : Public Health Wales: C. difficile, S. aureus and E.coli bacteraemia monthly dashboard (September 2018)

Measure 1: Rate of C.difficile cases per 100,00 of the population
Measure 2: Number of C.difficile cases
Measure 3: Number of cumulative cases of C.difficile against March 2019 reduction expectation

How are we doing?

- In September 2018, the Health Board's total number of cases was 9, this was 11 fewer cases than the IMTP profile.
- Of the 9 cases, 5 (56%) were hospital acquired infections (HAI); 4 (44%) were community acquired infections. Morriston Hospital Delivery Unit (DU) and Princess of Wales Hospital each accounted for 40% of the hospital acquired cases. Singleton Hospital DU accounted for 20% of HAI.
- The cumulative number of cases, April 2018 to September 2018, is 15 cases below the IMTP projected profile; the cumulative position to September 2018 is approximately 25% below the cumulative position for the same period in 2017.
- The significant drivers that have influenced this reduction are considered to be associated with:
  - the restriction of the broad –spectrum antibiotic Co-amoxiclav;
  - the restriction on placing additional beds/trolleys in existing full bays in Morriston Hospital as part of the pre-emptive policy; and
  - the decanting of bays to effect a thorough deep clean and disinfection of the areas occupied by patients with *C. difficile*.

What actions are we taking?

- Review compliance with restriction of Co-amoxiclav, with feedback to Delivery Units. **Impact: 50% reduction in annual Co-amoxiclav use by 31.03.19.**
- Re-introduction of UV-C Environment Decontamination System Task & Finish group inaugural meeting rescheduled to 06/11/2018 as key participants and staff side representatives had been unable to attend previously scheduled meeting.
- Implement weekly *Clostridium difficile* ward rounds on two sites initially (dependent of availability of PHW Microbiologist). Objective: to identify initial key control points for improvement – **by 31.10.18**.
- During first month in post (**October 2018**), IPC Quality Improvement (QI) Matron will meet with Delivery Units to scope out Quality Improvement PDSA programmes being undertaken and identify opportunities for shared learning and improvement.

What are the main areas of risk?

- Contributory factors: secondary care antibiotic prescribing; impact of high numbers of outliers on good antimicrobial stewardship; use of additional beds in already full bays as part of the pre-emptive bed protocols; suspension of enhanced decontamination technologies; lack of decant facilities which restricts ability to undertake deep-cleaning of clinical areas.
- *C. difficile* spores may be found in 49% rooms of patients with *C. difficile* infection; 29% rooms of asymptomatic carriers.
- Public Health Wales implemented a new, more sensitive testing methodology for *C. difficile*. The likely impact of this will be a 10-20% increase in the detection of *C. difficile* carriage.

How do we compare with our peers?

- In September 2018, ABMU had the fourth highest incidence of *C. difficil*e in comparison with the other major Welsh Health Boards.
- To date in 2018/19, ABMU has the second highest cumulative incidence of *C. difficile* in comparison with the other Welsh Health Boards.

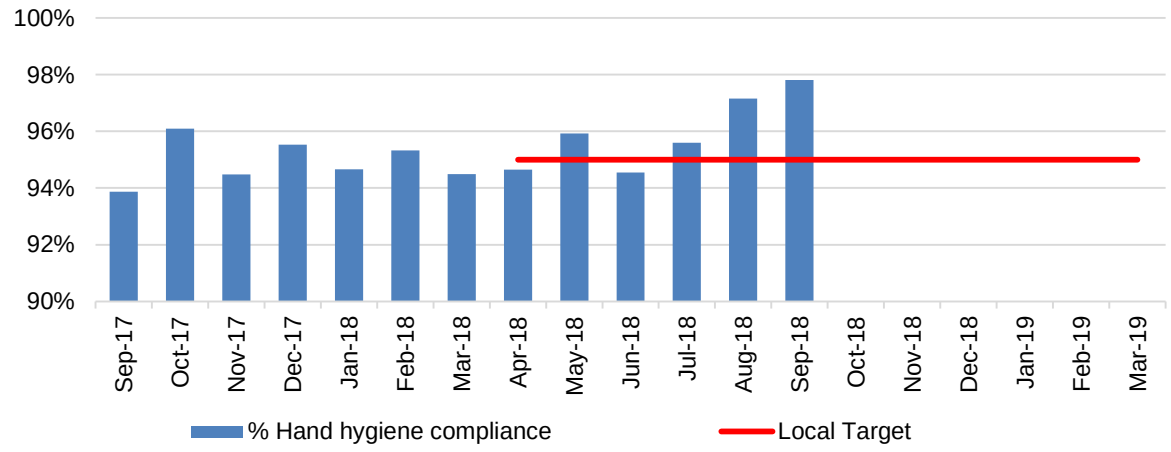
SAFE CARE - PEOPLE IN WALES ARE PROTECTED FROM HARM AND SUPPORTED TO PROTECT THEMSELVES FROM KNOWN HARM

Measure 1: % compliance with Hand Hygiene Audits

Corporate Objective : Delivering Excellent Patient Outcomes & Access			**Executive Lead :** Gareth Howells Director of Nursing & Patient Experience	
Period : September 2018	**IMTP Profile Target :** 95%	**WG Target :** N/A	**Current Status :** ✓	**Movement :** ↑ Improving

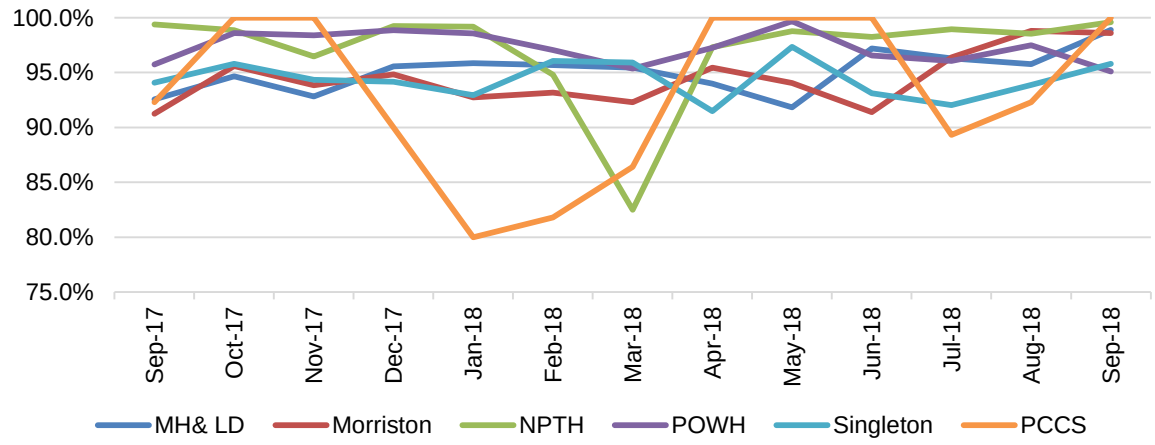
Current Trend: Sep 17 - Sep 18

(1) % compliance with Hand Hygiene Audits.



Benchmarking

(1) % compliance with Hand Hygiene Audits



Source : ABMU Care Metrics

Measure 1: % compliance with Hand Hygiene Audits

How are we doing?

- Compliance with hand hygiene (HH) for September 2018 was approximately 97%.
- For September 2018, 96 wards/units (65%) reported compliance ≥95%.
- 10 wards/departments (7%) reported compliance between 90% and 94%; 12 wards/units (8%) reported compliance of 89% or below.
- 30 wards/departments had not uploaded the results of their audits undertaken in September 2018.
- All six Service Delivery Units (SDU) reported compliance ≥95% in September 2018.
- Results over time indicate there are challenges to achieving sustained improvements in compliance however, there are recognised limitations with self-assessment.

What actions are we taking?

- Peer reviews (with neighbouring Health Boards) of hand hygiene compliance has not taken place since last winter due to competing service demands in all Health Boards. ABMU Infection Prevention & Control (IPC) team will discuss with the neighbouring Health Board IPC teams to agree whether this process can be recommenced.
- Delivery Units can agree internal peer review audit programmes, undertaking these between wards, specialties or Delivery Units.
- The updated Hand Hygiene Training programme is being delivered.

What are the main areas of risk?

- Main route of infection transmission is by direct contact, particularly by hands of staff.
- Poor compliance with good hand hygiene practice is likely to result in transmission of infection.
- Current scoring system may be giving an overly assuring picture of compliance; greater validation of the scores needs to be undertaken.
- The current system and format of scoring fails to highlight particular staff groups with lower compliance rates than others.

How do we compare with our peers?

- The HH score has been removed from the all-Wales dashboard because of the inherent difficulty in using one score to represent a whole Health Board.

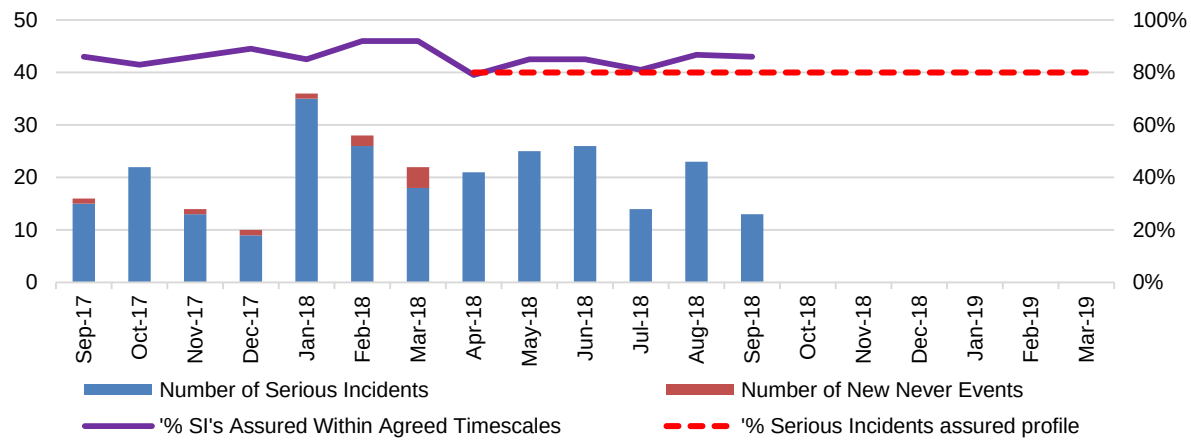
SAFE CARE - PEOPLE IN WALES ARE PROTECTED FROM HARM AND SUPPORTED TO PROTECT THEMSELVES FROM KNOWN HARM

Measure 1: Number of new Never Events
Measure 2: Number of new Serious Incidents (SI's)
Measure 3: % Serious Incidents Assured Within The Agreed Timescales

Corporate Objective : Embedding Effective Governance and Partnerships			**Executive Lead :** Gareth Howells Director of Nursing & Patient Experience	
Outcome Statement : I am safe and protected from harm through high quality care, treatment and support				
Period : September 2018	**IMTP Profile Target :** (1) 0, (2) 0, (3) 80%	**WG Target :** (1) 0, (3) 90%	**Current Status :** ✗	**Movement :** ↓ ● Improving

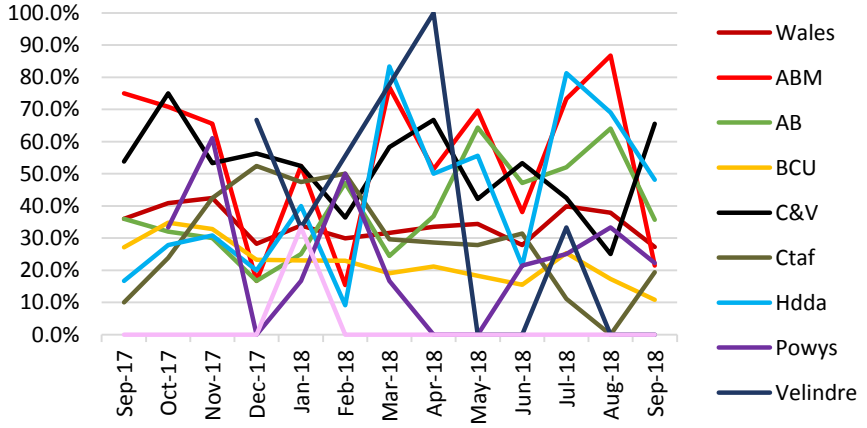
Current Trend: Sep 17 - Sep 18

(1) Number of new Never Events, (2) Number of new Serious Incidents (SI's), (3) % SI's Assured Within The Agreed Timescales



Benchmarking

Serious Incidents Assured Within The Agreed Timescales



Never Events

Sep-18	
Wales	4
ABM	0
AB	0
BCU	2
C&V	1
Ctaf	1
Hdda	0
Powys	0
Velindre	0
WAST	0

Source : NHS WALES OUTCOMES FRAMEWORK, ALL WALES PERFORMANCE SUMMARY (October 2018)

Measure 1: Number of new Never Events
Measure 2: Number of new Serious Incidents (SI's)
Measure 3: % Serious Incidents Assured Within The Agreed Timescales

How are we doing?

- Total number of incidents reported in September 2018 was 2,172. This compares to 1,990 incidents reported in September 2017, an increase of 182 incidents for the month of September (increase of 9%).
- 13 Serious Incidents (SI's) were reported to Welsh Government (WG) in September 2018 representing 0.6% of all incidents. In comparison, 16 SI's were reported to WG in September 2017, a decrease of 3 incidents (decrease of 23%). Of the 13 new serious incidents reported to WG in September 2018, 9 (69%) related to pressure ulcer incidents (grade 3 and above), 3 (23%) related to patient falls and 1 (8%) related to behaviour.
- In terms of severity of incidents, the percentage of incidents resulting in severe harm for September 2018 was 0.4% (total incidents reported 2,172). The Health Board's target for incidents resulting in severe harm is 0.5% of the total number of incidents reported.
- No Never Events were reported in September 2018.
- Performance against the WG target of closing SI's within 60 working days for September 2018 was 86% against the WG target of 80%.

What actions are we taking?

- The SI Team continues to trial the new reflective methodology approach to review serious incidents managed by the SI Team. Presentations promoting the approach are being undertaken across the Health Board to help promote an organisational learning culture. Positive feedback was received during learning event hosted by Princess of Wales Hospital on the 23 October 2018.
- The SI Team are leading on work to reduce variation in approaches to falls investigations. This includes the development of guidance to support reporting, investigation and learning from falls related incidents that resulted in severe harm. New investigation templates to support this work are currently being developed.
- In addition, recruitment to a new Concerns Quality Improvement Manager are progressing with appointment to the new post anticipated for mid-December 2018.

What are the main areas of risk?

- Maintaining Welsh Government 80% target closure date whilst ensuring quality of investigation reports and robust learning from the incidents.
- Differences between Welsh Government data and Health Board data.

How do we compare with our peers?

- Annual work plan updated for 2018/19 to include recommendations from the National inpatient falls audit. Plan will be monitored by the Falls Prevention Management Group.

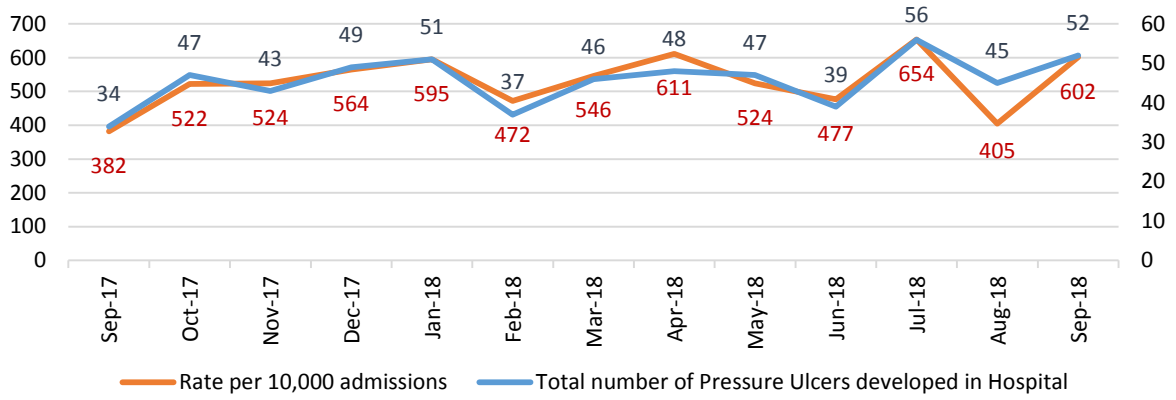
SAFE CARE - PEOPLE IN WALES ARE PROTECTED FROM HARM AND SUPPORTED TO PROTECT THEMSELVES FROM KNOWN HARM

Measure 1: Total Number of pressure ulcers acquired in hospital per 100,000 hospital admissions.
Measure 2: Number of grade 3, 4 suspected deep tissue injury and un-stageable pressure ulcers acquired in hospital per 100,000 hospital admissions.

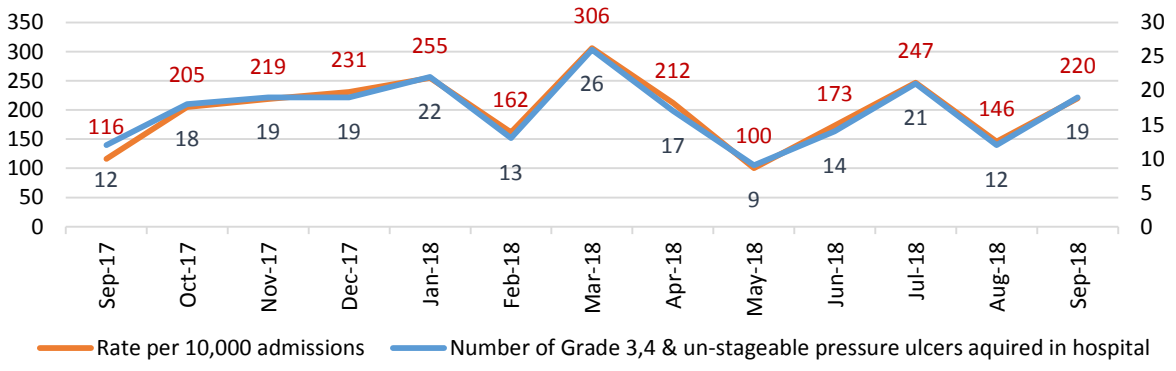
Corporate Objective : Embedding Effective Governance and Partnerships			**Executive Lead :** Gareth Howells Director of Nursing & Patient Experience	
Period : September 2018	**IMTP Profile Target :**	**Local Target :** 12 month reduction trend	**Current Status :** ✕	**Movement :** ↑ ● Worsening

Current Trend: Sep 17 - Sep 18

(1) Total Pressure Ulcers acquired in hospital.



(2) Grade 3, 4 suspected deep tissue injury and un-stageable pressure ulcers acquired in hospital



Benchmarking

Benchmarking data not available

Source : Pressure Ulcers from DATIX and Admissions from MYRDDIN

Measure 1: Total Number of pressure ulcers acquired in hospital per 100,000 hospital admissions.
Measure 2: Number of grade 3, 4 suspected deep tissue injury and un-stageable pressure ulcers acquired in hospital per 100,000 hospital admissions.

How are we doing?

- The "In Hospital" acquired Pressure Ulcers are reported as a rate per 100,000 hospital admissions to comply with the requirements of the NHS Wales Delivery Framework. The number of pressure ulcer incidents is also included to enable comparison with the reported measure of per 100,000 admissions.
- There has been an increase in the rate of pressure ulcer development for in-patients during September 2018. The rate per 100,000 admissions rose from 405 in August to 602 in September 2018. This reflects an increase in the number of pressure ulcers developing from 45 in August 2018 to 52 in September 2018.
- Princess of Wales Hospital continues to be a hotspot for pressure ulcer development and accounts for 29 (56%) of the 52 hospital acquired pressure ulcers developing in September.
- Of the 52 pressure ulcers reported in September 10 were categorised as Grade 1 (redness of intact skin).
- Device related pressure ulcers account for 2 of the reported pressure ulcers in September, a decrease from the 3 reported in August 2018.
- The rate of Grade 3+ pressure ulcers has increased from 146 per 100,000 admissions in August, to 220 per 100,000 admissions in September 2018.
- Of the 19 Grade 3+ pressure ulcer incidents reported in June, 2018, 1 was classified as deep damage and met the criteria for Serious Incident reporting.

What actions are we taking?

- The Pressure Ulcer Prevention Strategic Group (PUPSG) continues to meet quarterly with a multi-disciplinary membership and representation from all Service Delivery Units (SDU's).
- PUPSG are continuing to work closely with Welsh Risk Pool to deliver the Health Board Pressure Ulcer Strategic Quality Improvement Plan.
- An Independent review of Welsh Government Serious Incident reportable pressure ulcers for 2017-18 has been completed and the final report is to be presented at PUPSG in October.
- The review examined 43 hospital acquired incidents and identified 66% cases as being avoidable and 34% as unavoidable.
- 51% of cases occurred in the Princess of Wales Hospital.
- The review utilised the causal factor map developed by PUPSG and offers strong assurance that it is a valid tool for the identification of work streams to reduce avoidable pressure ulcers. The next steps will include analysis of the causal factors and development of specific work streams and measurement tools to reduce the risk of those factors.
- The most common causal factor for avoidable pressure ulcers was identified as inadequate frequency of patient repositioning. The revised Prevention and Management of Pressure Ulcers Policy clearly identifies the minimum requirement for repositioning for in-patients.
- Incomplete documentation continues to be a contributory factor. All SDU's have plans in place for pressure ulcer prevention documentation audit.
- Pressure Ulcer Peer Review Scrutiny Panels are held in all Service Delivery Unit's and learning from incidents translated into improved prevention plans and shared at the PUPSG meeting.
- An Internal Audit Report into Pressure Ulcer Prevention has given "Reasonable Assurance".

What are the main areas of risk?

- Continued difficulty with maintain nurse staffing levels on wards.

How do we compare with our peers?

- NOTE: The total rate per 100,000 admissions may increase despite total incidents decreasing based on the monthly admissions per 100,000 measure.

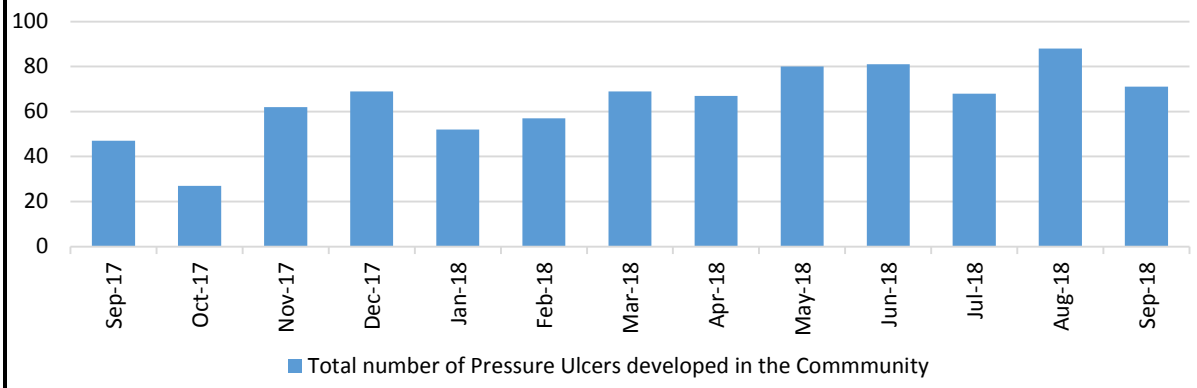
SAFE CARE - PEOPLE IN WALES ARE PROTECTED FROM HARM AND SUPPORTED TO PROTECT THEMSELVES FROM KNOWN HARM

Measure 1: Total Number of pressure ulcers developed in the community.
Measure 2: Number of grade 3, 4 suspected deep tissue injury and un-stageable pressure ulcers developed in the community.

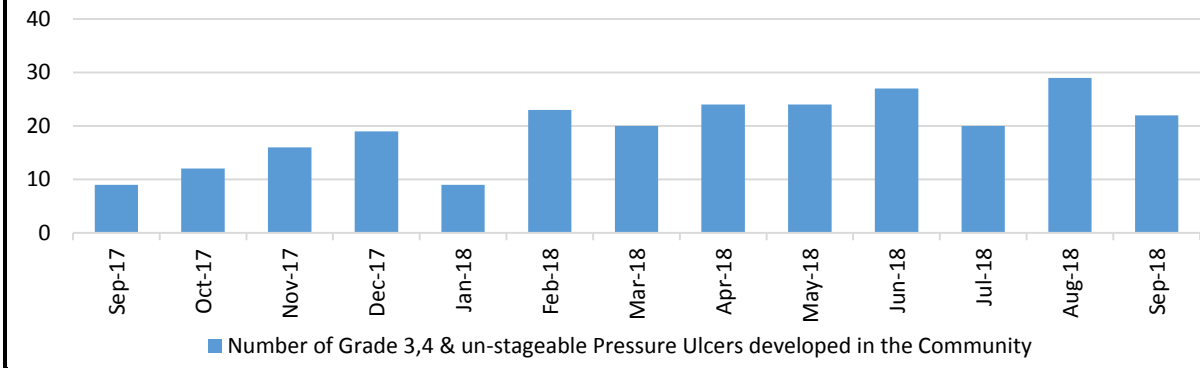
Corporate Objective : Embedding Effective Governance and Partnerships			**Executive Lead :** Gareth Howells Director of Nursing & Patient Experience	
Period : September 2018	**IMTP Profile Target :**	**Local Target :** 12 month reduction trend	**Current Status :** ✗	**Movement :** ↑ ● Worsening

Current Trend: Sep 17 - Sep 18

(1) Total Number of pressure ulcers developed in the community.



(2) Number of grade 3, 4 suspected deep tissue injury and unstageable pressure ulcers developed in the community.



Benchmarking

Benchmarking data not available

Source : Pressure Ulcers from DATIX

Measure 1: Total Number of pressure ulcers developed in the community.
Measure 2: Number of grade 3, 4 suspected deep tissue injury and un-stageable pressure ulcers developed in the community.

How are we doing?

- During September 2018, 71 incidents of pressure ulceration were reported in the community, this is a decrease compared to the 88 incidents reported in August 2018.
- Of the 71 pressure ulcers reported in September, 13 were categorised as Grade 1 (redness of intact skin).
- Device related damage accounts for 2 pressure ulcers, of those 1 was caused by a device owned by the patient.
- There has been a decrease in the number of Grade 3+ pressure ulcers reported, from 29 in September to 22 in June 2018.
- Of the Grade 3+ pressure ulcers reported in September, 5 were considered deep damage and met the criteria for Serious Incident (SI) reporting. This is a decrease from the 9 that met the criteria in August 2018

What actions are we taking?

- The Pressure Ulcer Prevention Strategic Group meeting (PUPSG) continues to meet quarterly. PUPSG are continuing to work closely with Welsh Risk Pool to deliver the Health Board Pressure Ulcer Strategic Quality Improvement Plan.
- An Independent review of Welsh Government Serious Incident reportable pressure ulcers for 2017-18 has been completed and the final report is to be presented at PUPSG in October.
- The review utilised the causal factor map developed by PUPSG and offers strong assurance that it is a valid tool for the identification of work streams to reduce avoidable pressure ulcers. The next steps will include analysis of the causal factors and development of specific work streams to reduce the risk of those factors.
- The review examined 125 incidents reported in community and identified 2 as device related and 15 as wrongly reported. 13 (12%) cases were identified as avoidable pressure ulcers and 95 (88%) as being as unavoidable.
- The most common causal factor for avoidable pressure ulcers was identified as inadequate frequency of patient repositioning. However, the frequency of repositioning in patient's homes is sometimes challenging due to patient choice and the availability of care services.
- A concordance policy has been written by Primary Community & Care with the aim of supporting staff to coproduce an acceptable plan of care for pressure ulcer prevention with the patient.
- Using mobilisation has increased the timeliness of home visits when early pressure damage is identified enabling earlier intervention and treatment and avoiding delays in management.
- Pressure Ulcer Peer Review Scrutiny Panels are held in all localities and learning from incidents translated into improved prevention plans and shared at the PUPSG meeting. Neath Port Talbot locality has the most established scrutiny panel process and has seen a significant improvement in pressure ulcer prevention.
- Education for pressure ulcer prevention and classification of pressure ulcers remains an ongoing priority. Bespoke sessions are delivered by Tissue Viability Nurses to community staff, carer organisations and care homes on a rolling programme.

What are the main areas of risk?

- The Primary Care & Community Services Delivery Unit are supporting large numbers of frail older people at home who are at increased risk of developing pressure damage.

How do we compare with our peers?

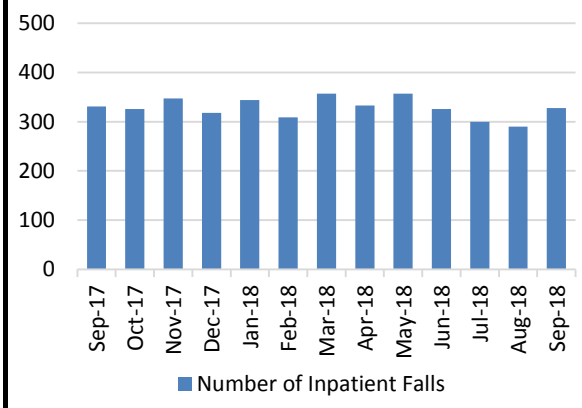
- No benchmark data available.

SAFE CARE - PEOPLE IN WALES ARE PROTECTED FROM HARM AND SUPPORTED TO PROTECT THEMSELVES FROM KNOWN HARM

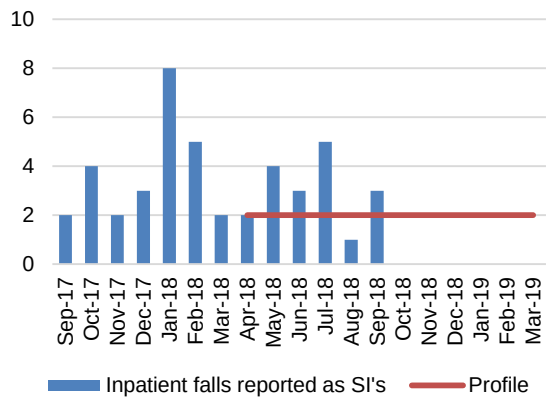
Measure 1: Total Number of Inpatient Falls
Measure 2: Number of inpatients falls reported as serious incidents

Corporate Objective : Embedding Effective Governance and Partnerships			**Executive Lead :** Gareth Howells Director of Nursing & Patient Experience	
Outcome Statement : I am safe and protected from abuse and neglect				
Period : September 2018	**IMTP Profile Target :** (2) 2	**WG/ Local Target :** (1) (2) 12 month reduction trend	**Current Status :** ✓	**Movement :** ↓ Improving
Current Trend: Sep 17- Sep 18				

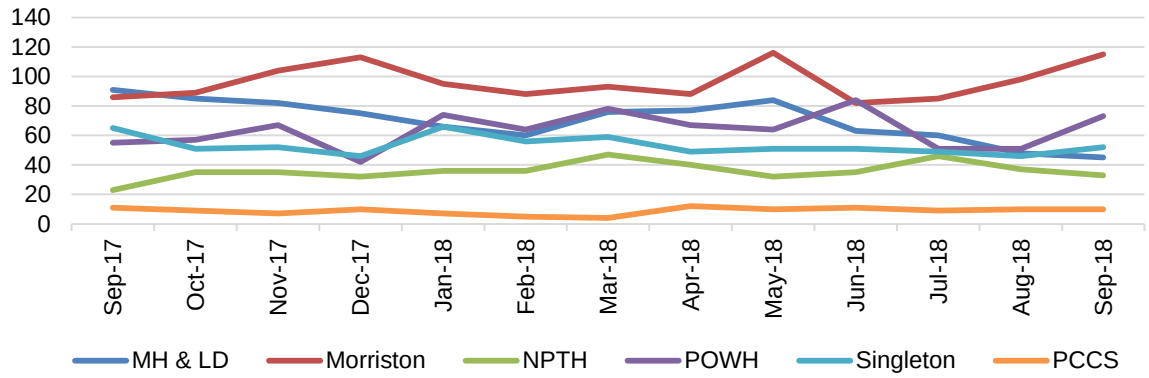
(1) Total number of Inpatient Falls



(2) Number of inpatients falls reported as serious incidents



(1) Number of Inpatient Falls



Benchmarking

No benchmarking data available

Source : INCIDENT DATA FROM DATIX

Measure 1: Total Number of Inpatient Falls
Measure 2: Number of inpatients falls reported as serious incidents

How are we doing?

- The number of falls reported via Datix in July, August and September 2018 showed a decrease for July (from 326 to 300), August (from 300 to 290) with September showing an increase of 38 from August but an overall increase of only 2 from June 2018.
- Morriston have shown an increase for all three months (July, August and September 2018) with an increase from June to September of 30. The number of serious incidents is awaiting verification from the delivery unit.
- Princess of Wales have shown a decrease of 30 from June to July and maintained this position until September showing an increase of 22. The number of serious incidents were 1 fracture femur in July and one in September.
- Singleton have maintained their June position until September which showed small increase (by 6). The number of serious incidents is awaiting verification from the delivery unit.
- Mental Health maintained their position in July and August and have seen a decrease of 15 from July to September. There were 3 serious incidents in the reporting period - 1 in each of the months of July, August and September.
- Neath Port Talbot have seen an overall decrease of 13 from July to September. There were 2 serious incidents in the reporting period - 1 in July (fractured femur) and 1 in August (C-spine)
- Primary and Community have maintained their positon from July to September, The number of serious incidents is awaiting verification from the delivery unit.

What actions are we taking?

- The Falls Policy has now been approved by the Health Board, an implementation plan is progressing.
- A teaching presentation on the new falls policy has been developed and distributed to all delivery units.
- The terms of reference of the Falls group are currently being revised to ensure there is wider multi agency membership.

What are the main areas of risk?

- The Health Board (HB) policy has not yet been implemented – corporate teams will support the implementation plan.
- Hi-lo beds purchased by Health Board have now been placed on the risk register as the company have gone into administration. Awaiting update from procurement re. maintenance contracts; SBAR developed and shared with all delivery units to ensure all staff have been informed of how to quarantine any affected beds. In the interim the HB will potentially need to hire in further stock of Hi low beds from an alternative manufacturer.

How do we compare with our peers?

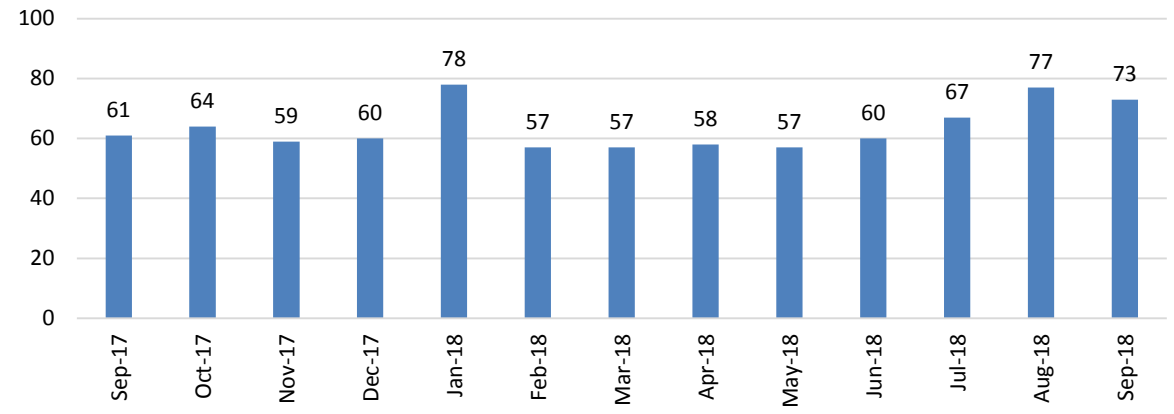
- Annual work plan updated for 2018/19 to include recommendations from the National inpatient falls audit. Plan will be monitored by the Falls Prevention Management Group.

SAFE CARE - PEOPLE IN WALES ARE PROTECTED FROM HARM AND SUPPORTED TO PROTECT THEMSELVES FROM KNOWN HARM

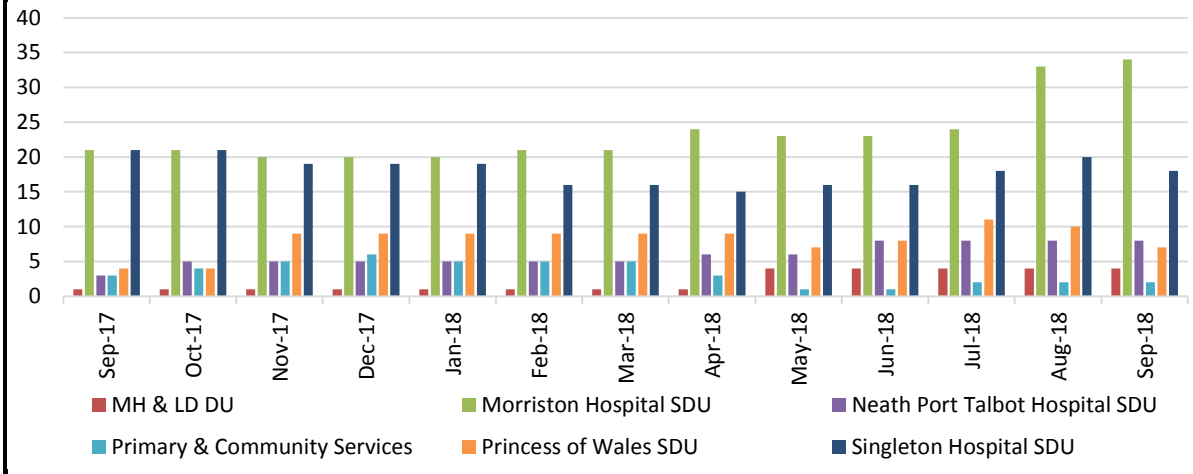
Measure 1: Number of risks with score ≥ 20

Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			**Executive Lead :** Gareth Howells Director of Nursing & Patient Experience	
Period : September 2018	**IMTP Profile Target :**	**Local Target :** 12 month reduction trend	**Current Status :** ✕	**Movement :** ↑ Worsening
Current Trend: Sep 17 - Sep 18				

(1) Number of risks with score ≥ 20



(1) Number of risks with score ≥ 20 (by Service Delivery Unit



Benchmarking

No Benchmarking Data Available.

Source : ABMU Datix System

Measure 1: Number of risks with score ≥ 20

How are we doing?

- 73 operational risks, rated 20. A decrease from 77 in August 2018.
- Morriston Delivery Unit has the highest number of risk rates 20 (34).

What actions are we taking?

- There have been two meetings of the Risk Management Group, the Terms of Reference, Simple Guide have been approved.
- Health Board Senior Executives have received training on the Datix Risk Module.
- Several Committees and Groups have been visited by Risk & Assurance team members to strengthen scrutiny of Risks on the various Health Board Risk Registers.
- Health Board Senior Executives have received training on the Datix Risk Module.
- A new training package on level 2 risk management is being developed.

What are the main areas of risk?

- The risk and Assurance team are currently reviewing all high-level risks on the risk register in conjunction with the appropriate Health Board Executives and Service Directors.

How do we compare with our peers?

- No comparable data available.

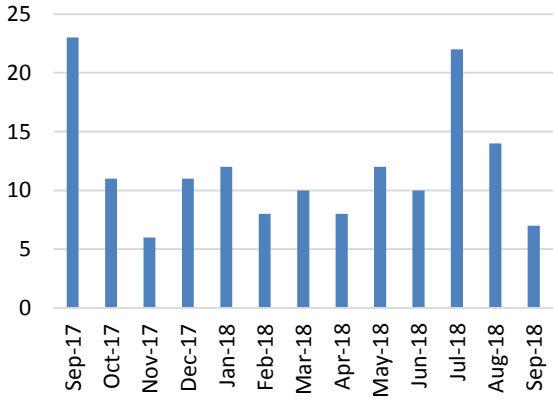
SAFE CARE - PEOPLE IN WALES ARE PROTECTED FROM HARM AND SUPPORTED TO PROTECT THEMSELVES FROM KNOWN HARM

Measure 1: Number of Safeguarding Adult referrals relating to Health Board staff/ services
Measure 2: Number of Safeguarding Adult referrals relating to Health Board staff/ services by Service Delivery Unit
Measure 3: Themes of Safeguarding Adult (POVA) reports (Health Board Total)
Measure 4: Themes of Safeguarding Adult (POVA) reports by Service Delivery Unit

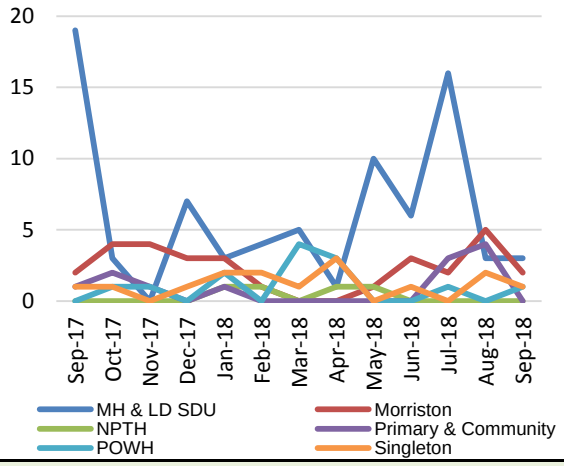
Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			**Executive Lead :** Gareth Howells Director of Nursing & Patient Experience	
Period : September 2018	**IMTP Profile Target :** N/A	**Local Target :** (1) (2) Reduce (3) (4) Monitor	**Current Status :** ✗	**Movement :** ↑ ● Worsening

Current Trend: Sep 17 - Sep 18

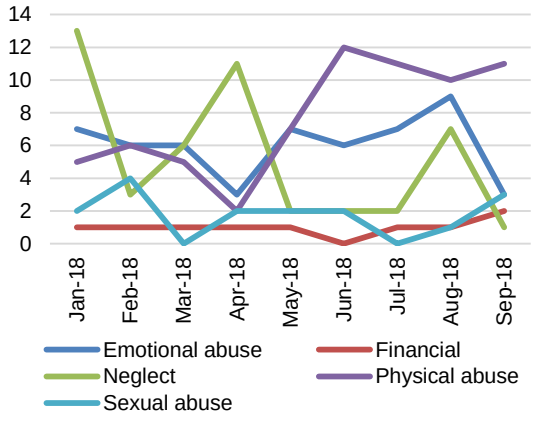
(1) Number of Safeguarding Adult referrals relating to Health Board staff/services (HB Total)



(2) Number of Safeguarding Adult referrals relating to Health Board staff/ services by Service Delivery Unit



(3) Themes of Safeguarding Adult (POVA) reports (HB Total)



(4) Themes of Safeguarding Adult (POVA) reports (by SDU)

Sep-18						
	Emotional abuse	Financial	Neglect	Physical abuse	Sexual abuse	Total
MH & LD SDU	3	2		7	3	15
Morriston Hospital SDU				3		3
NPT Hospital SDU						0
Princess of Wales SDU			1			1
Singleton Hospital SDU				1		1
P & CC SDU						0
Total	3	2	1	11	3	20

Benchmarking

No Benchmarking Data Available.

Source : ABMU Datix System

Measure 1: Number of Safeguarding Adult referrals relating to Health Board staff/ services
Measure 2: Number of Safeguarding Adult referrals relating to Health Board staff/ services by Service Delivery Unit
Measure 3: Themes of Safeguarding Adult (POVA) reports (Health Board Total)
Measure 4: Themes of Safeguarding Adult (POVA) reports by Service Delivery Unit

How are we doing?

- (1) The number of safeguarding adult at risk referrals relating to Health Board (HB) staff or services continue to vary each month, with a peak noted in July. However, the mean number of such referrals for October 2017 to September 2018 at 10.91 is only slightly higher than the mean for the corresponding period in 2016-17 (10.33).
- (2) No Service Delivery Unit received more than five referrals related to HB staff or services in both August and September, with Mental Health & Learning Disabilities having the greatest reduction.
- (3/4) Mental Health & Learning Disabilities Service Delivery Unit consistently have the highest number of adult at risk referrals. This is expected due to the complexities and vulnerabilities of their client group. Most of referrals managed by the Service Delivery Unit relate to allegations of abuse of a patient by another patient.

What actions are we taking?

- Service Delivery Units report on lessons identified from closed safeguarding cases in their unit performance reports to the Safeguarding Committee. This allows learning from specific cases to be shared across the Health Board.
- The themes and trends of adult safeguarding cases across the Health Board are being reported and analysed by the Corporate Safeguarding team. This information is presented to both the Safeguarding Committee and Quality and Safety Committee in the bi-annual Safeguarding Report

What are the main areas of risk?

- Achieving legislative requirements of timescales to complete initial enquiries for safeguarding adult referrals – this is recorded within the Corporate Safeguarding Team, and Service Delivery Units are required to report breaches on their performance reports.
- The Health Board is engaging with the three Local Authority areas to implement a robust process in order to fulfil its duty to report adults at risk to the Local Authority.

How do we compare with our peers?

- Peer information is not available for comparison

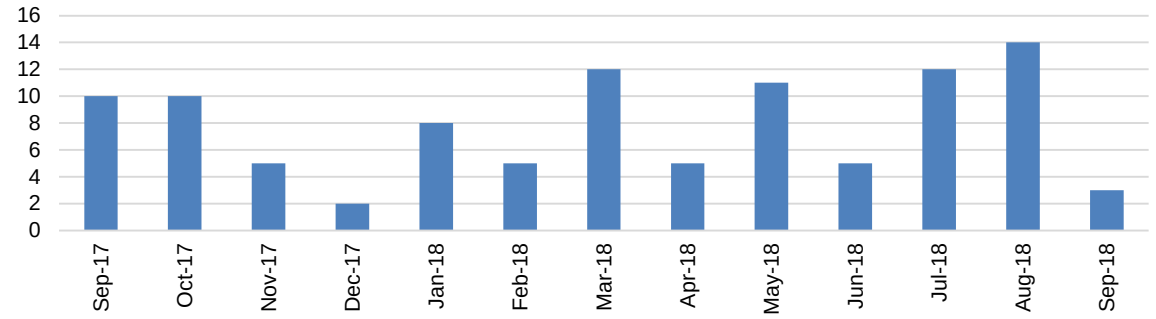
SAFE CARE - PEOPLE IN WALES ARE PROTECTED FROM HARM AND SUPPORTED TO PROTECT THEMSELVES FROM KNOWN HARM

Measure 1: Number of Safeguarding Children Incidents

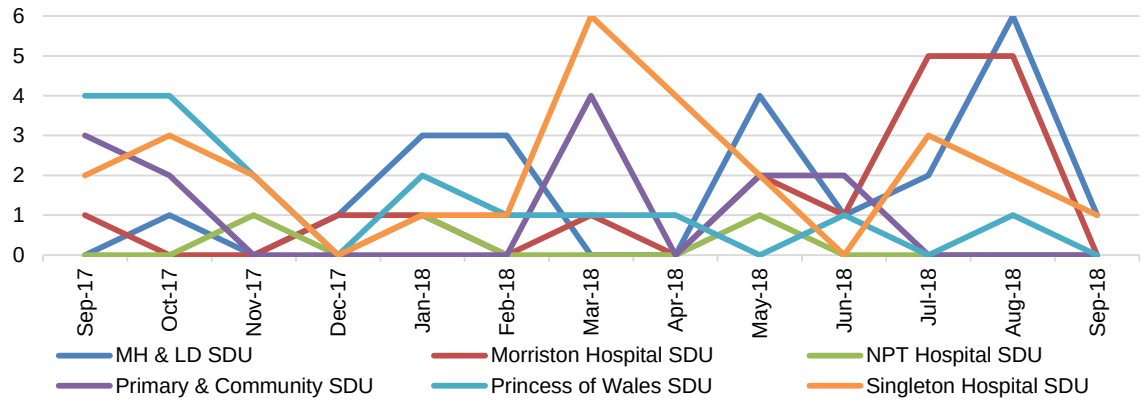
Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			**Executive Lead :** Gareth Howells Director of Nursing & Patient Experience	
Period : September 2018	**IMTP Profile Target :** N/A	**Local Target :** 0	**Current Status :** ✕	**Movement :** ↑ ● Worsening

Current Trend: Sep 17 - Sep 18

(1) Number of Safeguarding Children Incidents



(1) Number of Safe guarding Children Incidents



Benchmarking

No Benchmarking Data Available.

Source : ABMU Datix System

Measure 1: Number of Safeguarding Children Incidents
How are we doing?
• Children's incident reporting has increased in the last three months, the numbers are still relatively low and so recognising themes and trends are difficult to identify, however there has been a noticeable increase in the reporting of Children being nursed on Adult wards. Service Delivery Units (SDUs) have been reminded to incident report any child that has been admitted to an adult ward and to complete the Risk Assessment Tool for Children admitted to Adult Ward Environments to ensure that Safeguarding has been considered and put in place by ward staff. • The Health Board (HB) does not capture any Health Board Safeguarding Children referrals to Children's Services in the Local Authority (LA) and so this activity is not visible on the Report Cards. The data is currently collated by contacting the LA.
What actions are we taking?
• The Children's Trigger list is currently being updated, and a link will be added on Datix giving guidance for Safeguarding children's Incident alerts. The new list will be presented to the Safeguarding Committee in November. • The Corporate Safeguarding team undertook a snapshot audit of reported incidents in September to review any underreporting of Children's Incidents and reasons for underreporting. There was no evidence of under reporting which is reassuring. • Safeguarding Children's referrals that are made by HB staff are sent directly to the Local Authority and as such the HB does not have an accurate record of Children's safeguarding referrals that have been made. The Corporate Safeguarding team are developing with the Datix team a data collection tool that will capture relevant information from all HB referrals. Anticipated date of completion December 2018.
What are the main areas of risk?
• The data reporting tool for Children's safeguarding referrals is currently under development, until this has been developed there is no robust method to capture all Safeguarding Children activity across ABMU HB. The Service Delivery Units do report on any Safeguarding Children's referrals within their bi-monthly performance reports to the Safeguarding Committee but these are not reflective of all activity.
How do we compare with our peers?
• Comparison data from peer organisations not available

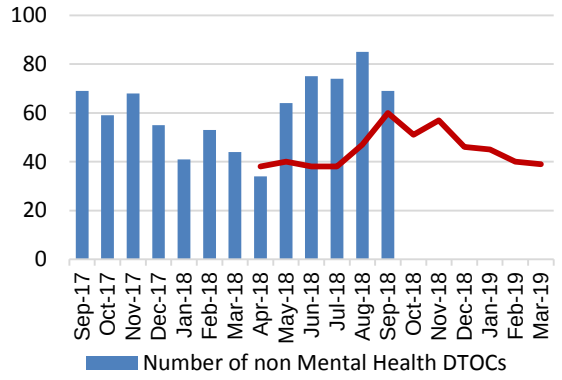
9.3 Effective Care

EFFECTIVE CARE - PEOPLE IN WALES RECEIVE THE RIGHT CARE AND SUPPORT AS LOCALLY AS POSSIBLE AND ARE ENABLED TO CONTRIBUTE TO MAKING THAT CARE

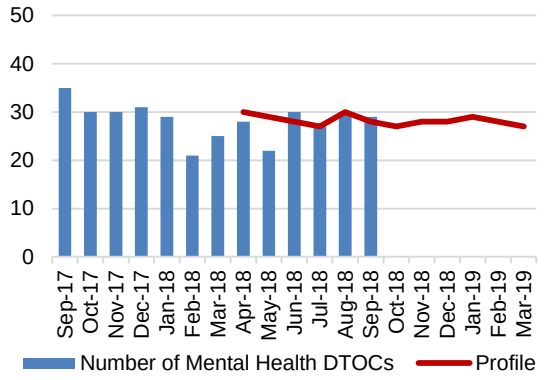
Measure 1: Number of Delayed Transfers of Care (DTOCs) for non-mental health specialities (age 75+)
Measure 2: Number of Delayed Transfers of Care (DTOCs) for mental health (all ages)
Measure 3: Number of non-mental health Delayed Transfers of care (Rolling 12 months)
Measure 4: Number of mental health Delayed Transfers of Care (Rolling 12 months)

Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			**Executive Lead :** Darren Griffiths Associate Director of Performance	
Outcome Statement : Health care and support are delivered at or as close to my home as possible				
Period : September 2018	**IMTP Profile Target :** (1) 60 (2) 28	**WG Target :** (3) Reduce by 10% (4) Reduce by 5%	**Current Status :** ✗	**Movement :** ↑ ● Worsening
Current Trend: Sep 17 - Sep 18				

Measure 1: Number of Delayed Transfers of Care (DTOCs) for non-mental health specialities (age 75+)

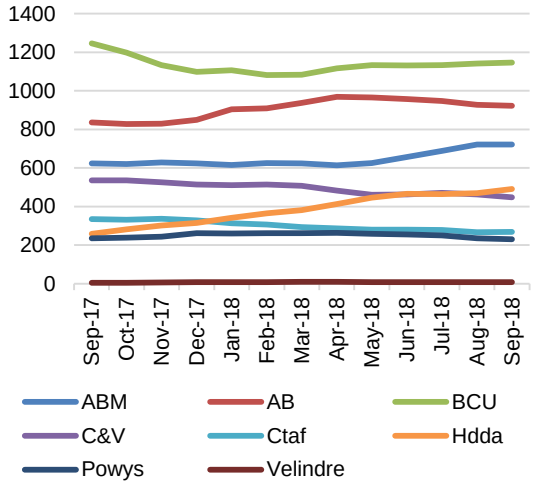


Measure 2: Number of Delayed Transfers of Care (DTOCs) for mental health (All ages)

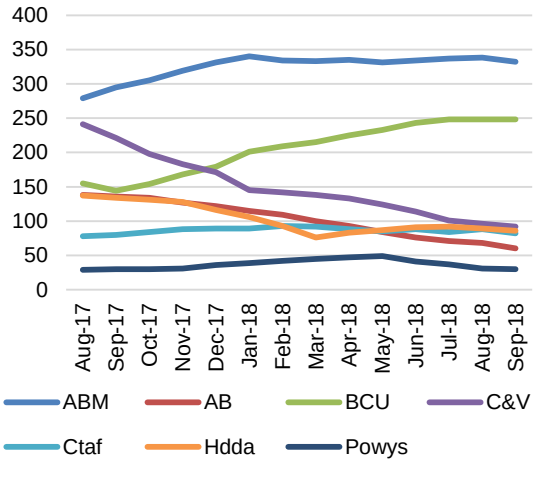


Benchmarking

Measure 3: Number of non-mental health Delayed Transfers of care (Rolling 12 months)



Measure 4: Number of mental health Delayed Transfers of Care (Rolling 12 months)



Source : NHS WALES OUTCOMES FRAMEWORK, ALL WALES PERFORMANCE SUMMARY (September 2018)

Measure 1: Number of Delayed Transfers of Care (DTOCs) for non-mental health specialities (age 75+)
Measure 2: Number of Delayed Transfers of Care (DTOCs) for mental health (all ages)
Measure 3: Number of Delayed Transfers of Care (DTOCs) per 10,000 LA population for non-mental health specialities (age 75+)
Measure 4: Number of Delayed Transfers of Care (DTOCs) per 10,000 LA population for mental health (all ages)

How are we doing?

- The total number of residents reported as a delayed discharge at a Health Board site in September 2018 was 98 which was a positive reduction when compared with the 115 patients reported in August, and also a reduction when compared with 104 delayed transfers of care reported in September 2017.
- The overall bed days associated with delayed transfers of care in September 2018 has however increased by 44% compared with September 2017, from 5,135 bed days to 7,382 bed days.

What actions are we taking?

- The Delivery Unit presented feedback to the unscheduled care board in October on the findings of the complex discharge audit which was undertaken in all of our hospitals in August. The feedback, alongside the findings of the inpatient bed utilisation survey undertaken in early October, will inform the development of a prioritised work programme to deliver systematic improvement in our patient flow and discharge processes, and which will be overseen by the unscheduled care USC delivery board.
- Strengthening frailty models within the Health board that support admission avoidance and which will impact on reducing DToC'S.
- The Health Board's patient flow and discharge policy is also under review with the aim of completing this process by the end of December 2018.

What are the main areas of risk?

- Capacity in the care home sector and fragility and capacity of the domiciliary care market in some parts of the Health Board.
- Risks of patient de-conditioning in the frail elderly population if hospital stays are prolonged.
- Workforce capacity including social work capacity.
- Effective Implementation of the patient choice policy and the discharge policy.
- Capacity to support ongoing care needs and patient placements out of area.

How do we compare with our peers?

- Delayed transfers of care continue to be a challenge for many Health Boards across Wales.

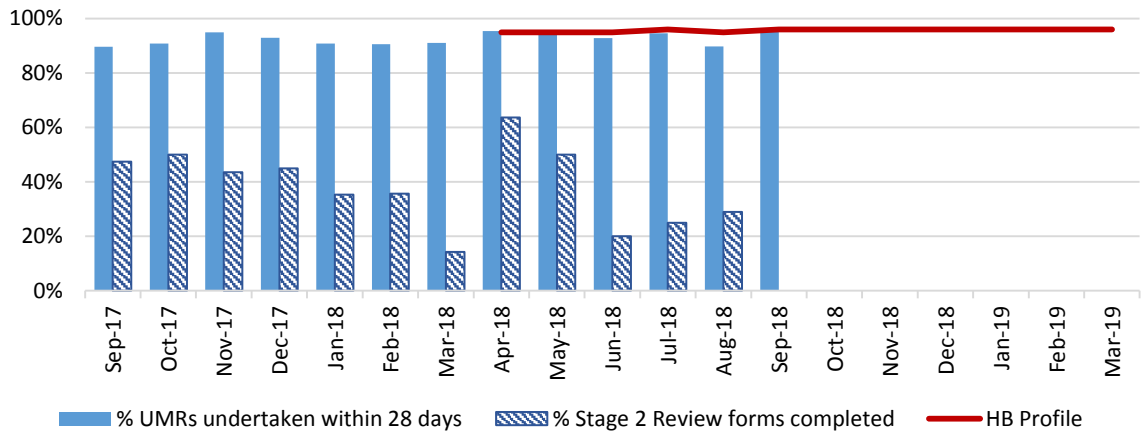
EFFECTIVE CARE - PEOPLE IN WALES RECEIVE THE RIGHT CARE AND SUPPORT AS LOCALLY AS POSSIBLE AND ARE ENABLED TO CONTRIBUTE TO MAKING THAT CARE

Measure 1: % Universal Mortality Reviews (UMR) undertaken within 28 days of death.
Measure 2: % Stage 2 Review forms completed.

Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access **Outcome Statement :** Interventions to improve my health are based on good quality and timely research and best practice			**Executive Lead :** Alastair Roeves Interim Medical Director	
Period : September 2018	**IMTP Profile Target :** (1) 95%	**WG Target :** (1) 95%	**Current Status :** ✓	**Movement :** ↑ Improving

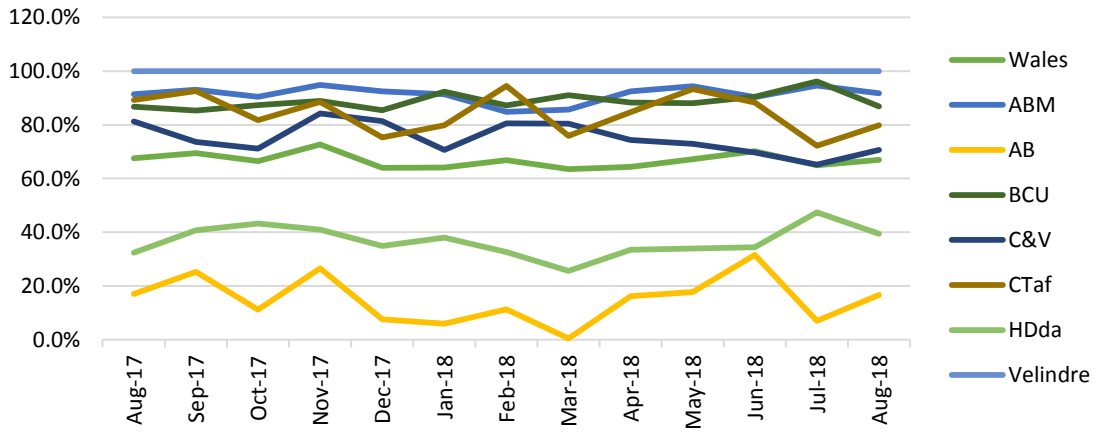
Current Trend: Sep 17 - Sep 18

(1) % Universal Mortality Reviews (UMR) undertaken within 28 days of death (2) % Stage 2 Review forms completed



Benchmarking

(1) % Universal Mortality Reviews (UMR) undertaken within 28 days of death



Source : NHS WALES OUTCOMES FRAMEWORK, ALL WALES PERFORMANCE SUMMARY (October 2018)

Measure 1: % Universal Mortality Reviews (UMR) undertaken within 28 days of death.
Measure 2: % Stage 2 Review forms completed.
Measure 3: Number of Hospital Deaths of persons over the age of 16 (Excluding Emergency Department)

How are we doing?

- Welsh Government Mortality Review Performance - ABMU achieved 96% completion of UMRs within 28 days of death in July. The overall Wales compliance was 65%.
- The Health Board UMR rate in September was 96%, 6% higher than August.
- Singleton and Neath Port Talbot Hospital (NPTH) achieved 100%, Princess of Wales Hospital (POWH) 97% and Morriston 93%.
- There were 10 missing UMR forms, 8 in Morriston and 2 in POWH.
- 15 (6%) of UMRs triggered a Stage 2 review in September. This is comparable with other Health Boards.
- Completion of Stage 2 reviews within 8 weeks (July deaths) was 25%. There are 50 outstanding Stage 2 reviews from April 2017.
- Mental Health and Community data are unavailable via the eMRA application at present. This is being addressed by Informatics.
- Thematic (Stage 3) reviews - Nothing untoward was found in the majority of thematic reviews. Where a theme was identified, falls were the most common in the past 6 months.

What actions are we taking?

- Morriston Delivery Unit (DU) has revised its process of death certification to improve the quality and timeliness of certification and to ensure that a UMR is completed every time. The new process has now been implemented by the Patient Affairs Team. They are working with doctors across the DU to raise awareness of the change and reinforce the requirement to complete the UMR as part of the administration process when a patient dies. There are fewer missing UMRs at Morriston month on month which suggests that the changes are having a positive impact.
- In Medicine at Singleton, all the Stage 2 reviews are discussed at their regular audit meetings.
- MH&LD - The updated Mortality Review Part 1 form is now in operation across the health Board identifying patients who have mental health, dementia or learning disability diagnosis. This is allowing input from Mental Health services where a Part 2 mortality review is required. The unit is in the process of allocating consultants to review the cases that have been identified. The Delivery Unit is involved in work with Public Health Wales to further develop the links with physical health care services and further develop the use of the Mortality Review process to improve learning for people with mental health problems and learning disabilities.
- Recent change of Unit Medical Director in POWH provides opportunity to review status of the Mortality Review process.

What are the main areas of risk?

- Timeliness of Stage 2 completion. This is being addressed by a differential approach to backlog cases and current cases to ensure that in future the focus is on current learning.
- Future implementation (April 2019, initially phased) of the Medical Examiner role is accompanied by risk of increased numbers of ‘Stage 2’ reviews required: the Medical Examiner role will effectively deliver Stage 1 reviews. It is recognised that phased implementation and as yet uncertain recruitment mean the impact will be similarly phased.

How do we compare with our peers?

- ABMU is the top ranking Health Board for the percentage of mortality reviews undertaken within 28 days of death. ABMU achieved 92% completion of UMRs within 28 days of death in August. The overall Wales compliance was 67%.

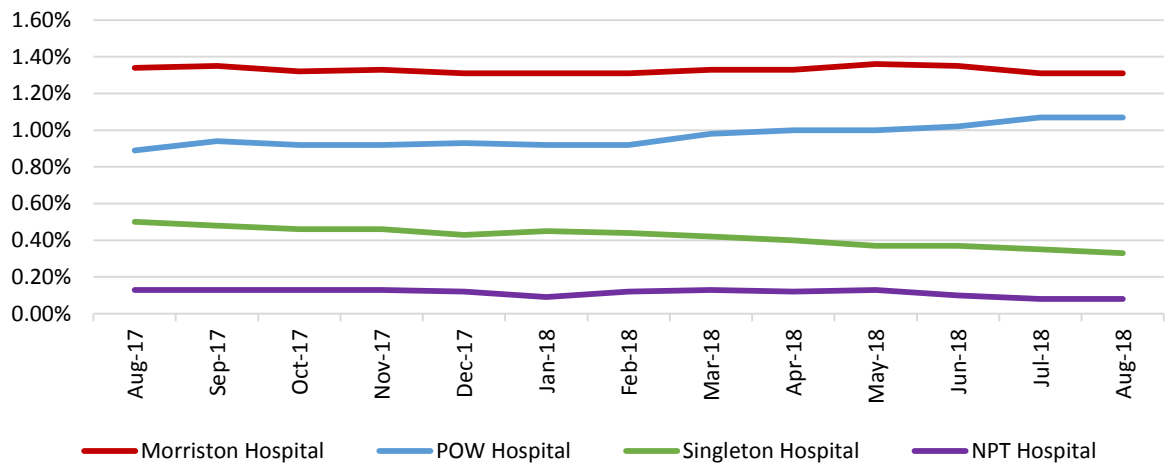
EFFECTIVE CARE - PEOPLE IN WALES RECEIVE THE RIGHT CARE AND SUPPORT AS LOCALLY AS POSSIBLE AND ARE ENABLED TO CONTRIBUTE TO MAKING THAT CARE

Measure 1: Crude hospital mortality rate (less than 75 years of age)

Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			**Executive Lead :** Alastair Roeves Interim Medical Director	
Outcome Statement : Interventions to improve my health are based on good quality and timely research and best practice				
Period : August 2018	**IMTP Profile Target :**	**WG Target :** 12 month reduction trend	**Current Status:** ✓	**Movement :** ↓ Improving

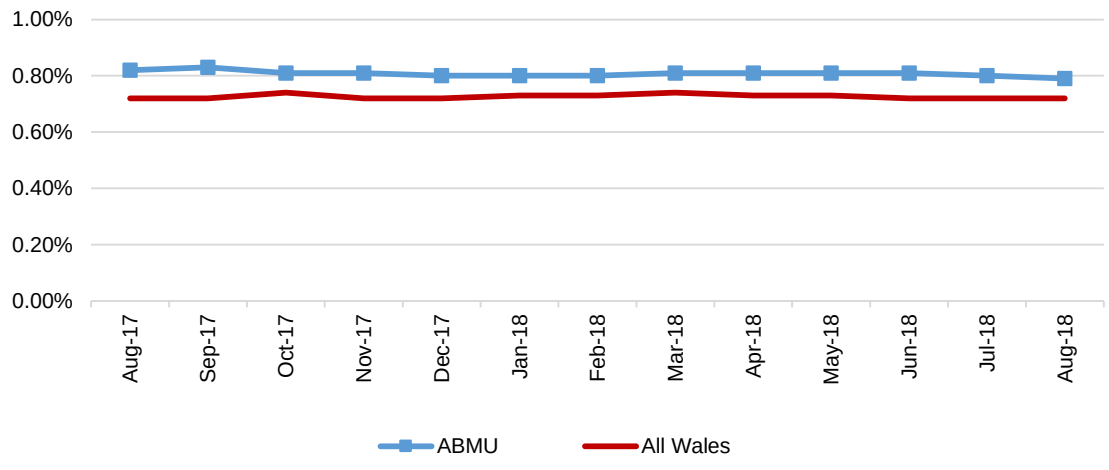
Current Trend: Aug 17 - Aug 18

(1) Crude hospital mortality rate (less than 75 years of age)



Benchmarking

(1) Crude hospital mortality rate (less than 75 years of age)



Source : NHS WALES OUTCOMES FRAMEWORK, ALL WALES PERFORMANCE SUMMARY (October 2018)

Measure 1: Crude hospital mortality rate (less than 75 years of age)

How are we doing?

- The ABMU Crude Mortality Rate for under 75s in the 12 months to August 2018 was 0.79%, compared with 0.82% for the same period last year.
- Site level performance is as follows: (previous year in brackets) Morriston 1.31% (1.34%), Princess of Wales 1.07% (0.89%), Neath Port Talbot 0.08% (0.13%), Singleton 0.33% (0.50%). Site comparison is not possible due to different service models being in place.
- There were 101 in-hospital Deaths in this age group in September 2018 the same as September 2018: Morriston 50 (57), Princess of Wales Hospital 25 (32), Neath Port Talbot Hospital 3 (1), and Singleton 20 (20).
- The number of deaths for Surgical and Elective cases remains consistently low for this age group.
- In the last 12 months the mortality rate at Princess of Wales has risen. Analysis undertaken has shown the number of deaths is not increasing but just demonstrating natural seasonal variation, while the number of patient episodes (the denominator in the calculation) has noticeably decreased. There are two reasons for this, the first being a change of process – some dermatology cases were being incorrectly recorded as day cases, while at other sites they were being recorded as outpatients which are not included in the calculated rate. Secondly, there are currently missing obstetric episodes which the Maternity Service have agreed to retrospectively input the missing data. This will increase the number of episodes included in the calculated rate.

What actions are we taking?

- All Unit Medical Directors have access to the Mortality Dashboard to enable them to review mortality data and mortality review performance and learning.
- Reporting and assurance arrangements for mortality review performance and learning will be reviewed by the incoming Executive Medical Director.

What are the main areas of risk?

- There is a risk of harm going undetected resulting in lessons not being learned. Our approach is designed to mitigate this risk and ensure effective monitoring, learning and assurance mechanisms are in place.

How do we compare with our peers?

- ABMU are above the all-Wales Mortality rate for the 12 months to August 18 – 0.79% compared with 0.72%.
- ABMU is the best Performing Health Board in respect of UMRs completed within 28 days of the patient's death

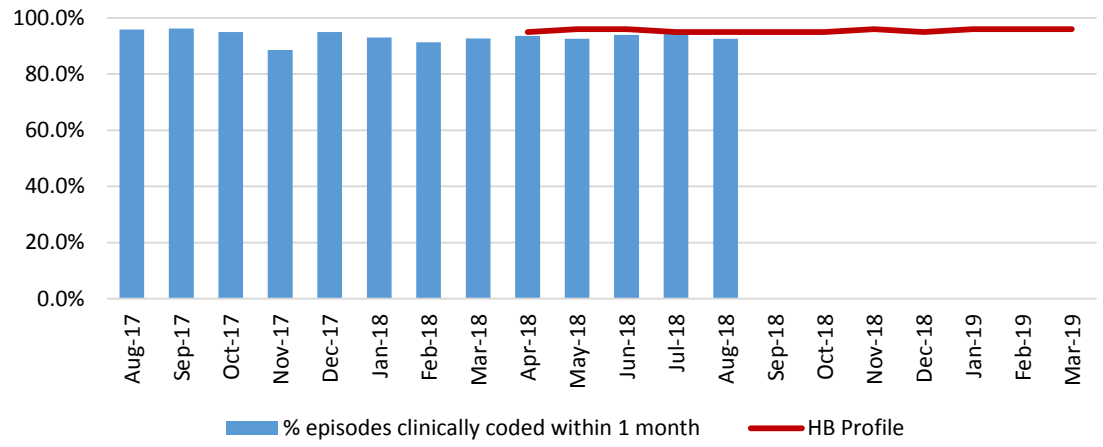
EFFECTIVE CARE - PEOPLE IN WALES RECEIVE THE RIGHT CARE AND SUPPORT AS LOCALLY AS POSSIBLE AND ARE ENABLED TO CONTRIBUTE TO MAKING THAT CARE

Measure 1: % episodes clinically coded within one month post episode end date

Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access **Outcome Statement :** Interventions to improve my health are based on good quality and timely research and best practice			**Executive Lead :** Matt John Interim Chief Information Officer	
Period : August 2018	**IMTP Profile Target :** 95%	**WG Target :** 95%	**Current Status :** ✗	**Movement :** ↓ Worsening

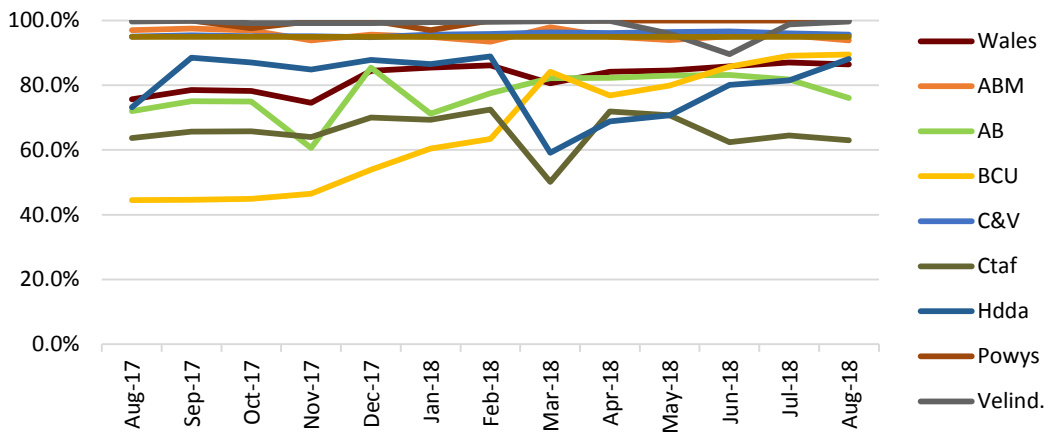
Current Trend: Aug 17 - Aug 18

(1) % episodes clinically coded within one month post episode end date



Benchmarking

(1) % episodes clinically coded within one month post episode end date



Source : NWIS Clinical Coding Extract September 2018

Measure 1: % episodes clinically coded within one month post episode end date
How are we doing?
• The completeness within 30 days for 2018/19 (snapshot positon) was, April 94%, May 93%, June 94%, July 95%, August 92%. • The department has achieved overall cumulative coding completeness for 2018/2019 as follows: April - 99%, May 98%, June 98%, July 97%. • Therefore despite narrowly missing the 'in month' (30 day) compliance by a number of days the cumulative position is exceeding the required performance levels and is performing amongst the best in Wales. • The NHS Wales Informatics Service (NWIS) national audit team carried out coding accuracy audits across all four main acute hospital sites during 2018. The Health Board has now received the full audit report and findings. The overall results of this audit confirm that the clinical coding have achieved above the recommended accuracy for secondary diagnosis, primary procedure and secondary procedure coding but did not achieve the recommended accuracy for primary diagnosis coding. The findings and recommendations will be incorporated into the Clinical Coding audit and development plans for 2018/19.
What actions are we taking?
• Review of roles and responsibilities in the department to ensure that processes are performing at optimum levels. • Continued training of the 6.5 WTE permanent staff which will address the completeness in month once staff are trained and competent. • Experienced coders are undertaking overtime to support the overall performance and effectiveness of the clinical coding service. • Detailed audit and improvement plans being proactively managed.
What are the main areas of risk?
• Maintaining the productivity levels in 2018/19 whilst the trainee Coders are still training and the contract coders are no longer employed and the availability of the Health Records in a timely manner.
How do we compare with our peers?
• The indicator above is now showing performance against the new target introduced for 2016/17 - 95% complete within 30 days (shown as a snapshot). ABMU is one of the top performing Health Boards. Currently Welsh Government cannot identify the date coded field in the APC extract and therefore the national coding extract is taken 2 weeks after the Health Board position is captured, therefore improving the completion compliance. As a result national reporting of ABMU compliance is higher than that reported internally. ABMU records and monitors the target correctly. NWIS are reviewing the APC extract to address this discrepancy.

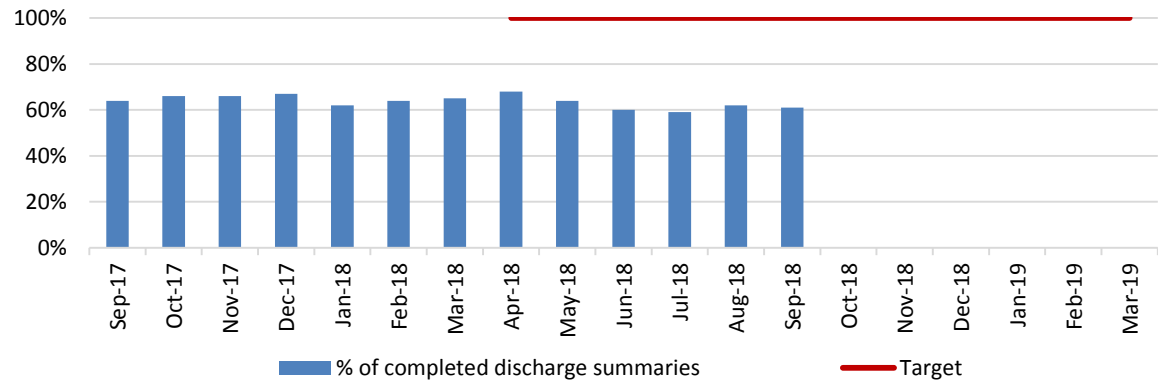
EFFECTIVE CARE - PEOPLE IN WALES RECEIVE THE RIGHT CARE AND SUPPORT AS LOCALLY AS POSSIBLE AND ARE ENABLED TO CONTRIBUTE TO MAKING THAT CARE

Measure 1: % of completed discharge summaries

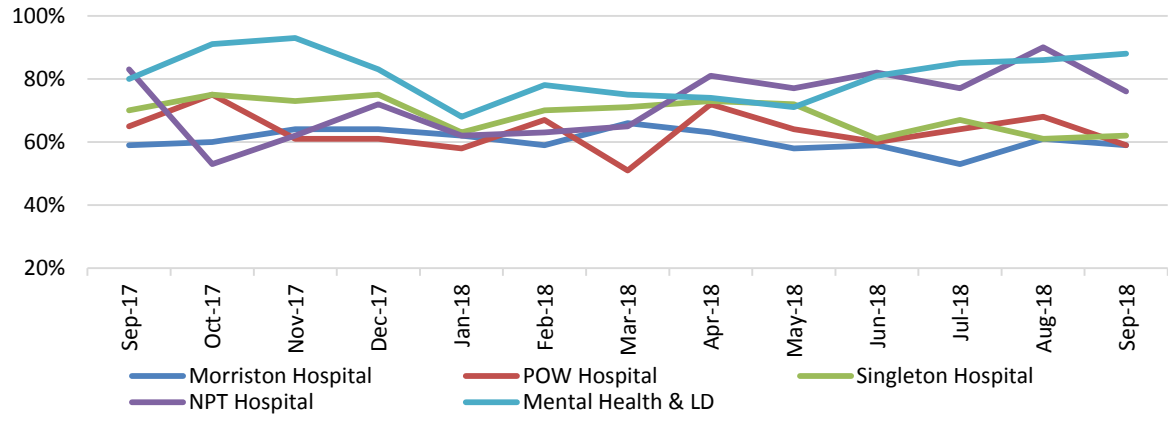
Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			**Executive Lead :** Alastair Roeves Interim Medical Director	
Period : September 2018	**IMTP Profile Target :** Improve	**Local Target :** 100%	**Current Status :** ✗	**Movement :** ↓ Worsening

Current Trend: Sep 17 - Sep 18

(1) % of completed discharge summaries ABMU



(1) % of completed discharge summaries (by Service Delivery Unit)



Benchmarking

Benchmarking data not available

Source : ETOC Dashboard

Measure 1: % of completed discharge summaries

How are we doing?

- Performance in this quality priority has declined slightly on a Health Board-wide basis in September (61%) compared with August (62%).
- Overall Health Board performance has not improved significantly over the past year.
- There continues to be performance variance between Service Delivery Units (62%-88%)
- This month the performance has improved in 2/5 Delivery Units, remained static in one and declined in the remaining two.
- In September Mental Health & Learning Disabilities was again the best performer, achieving 88%.
- The best performing acute site was Neath Port Talbot Hospital (76%).

What actions are we taking?

- The Executive Medical Director (MD) has asked Unit Medical Directors (UMDs) to consider how, and by whom, discharge summaries are completed and to invite members of the clinical teams other than doctors to contribute to them to ensure the highest quality and timely summary gets to the patient's GP. CNSs' are completing eToCs to a high standard in many specialties.
- E-Discharge - this is on the Work Programme for Morriston's Clinical Cabinet and Quality & Safety Meetings. It is hoped that the MTeD functionality due to be rolled out from Welsh Clinical Portal will support E-Discharges for Medicine.
- The Executive MD and the relevant UMDs has met with Trauma & Orthopaedic leads at Morriston and Princess of Wales Hospital to emphasise the need to prioritise discharge summaries.
- Singleton is undertaking an improvement project in relation to discharge summaries and how the Physician' Associate role could improve communication.
- The primary measure being used in Princess of Wales Hospital is percentage summaries completed within 24 hours of discharge. There have been notable improvements on individual wards.

- Risk to patient care and the need for readmission.

How do we compare with our peers?

- ABMU is the only health board to publish its performance.

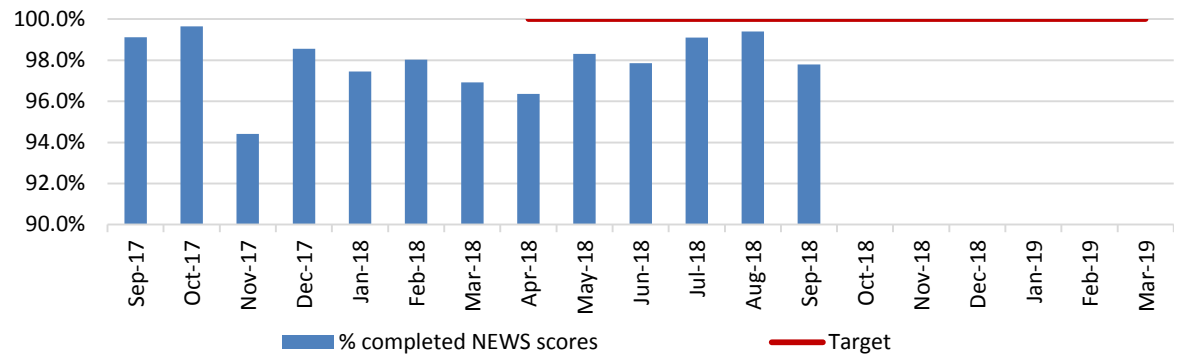
EFFECTIVE CARE - PEOPLE IN WALES RECEIVE THE RIGHT CARE AND SUPPORT AS LOCALLY AS POSSIBLE AND ARE ENABLED TO CONTRIBUTE TO MAKING THAT CARE

Measure 1: % patients with completed NEWS score and appropriate responses actioned

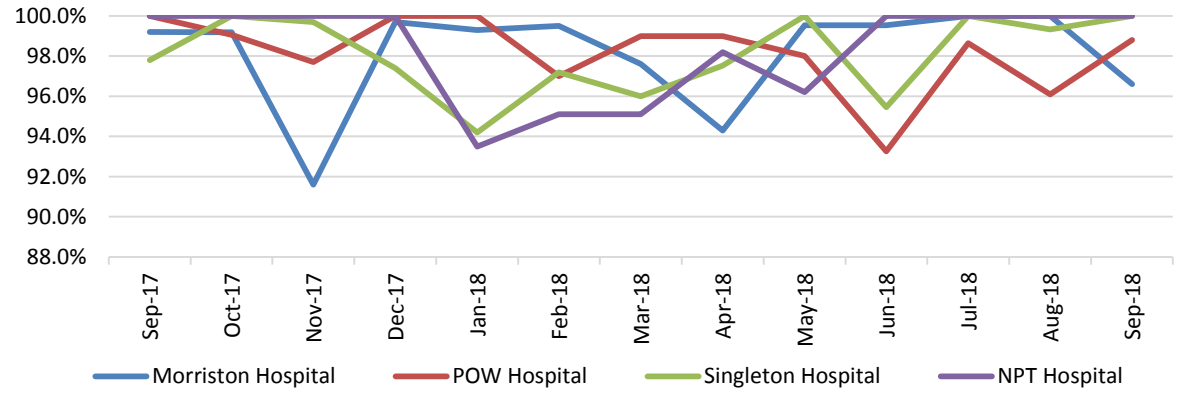
Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			**Executive Lead :** Alastair Roeves Interim Medical Director	
Period : September 2018	**IMTP Profile Target :** N/A	**Local Target :** 100%	**Current Status :** ✗	**Movement :** ↑ ● Improving

Current Trend: Sep 17 - Sep 18

(1) % patients with completed NEWS score and appropriate responses actioned.



(1) % patients with completed NEWS score and appropriate responses actioned (By Service Delivery Unit).



Benchmarking

No Benchmarking Data Available.

Source : ABMU Care Matrix

Measure 1: % patients with completed NEWS score and appropriate responses actioned

How are we doing?

- The overall Health Board percentage of patients with a completed NEWS Score in September 2018 was 97.8% compared with 99.4% in August and 99.1% in September 2017.
- In month performance improved in 2/4 Delivery Unit's (DU), remained static in 1/4 and declined in the remaining one.
- Neath Port Talbot (NPT) achieved 100% again in September.
- Morriston achieved 96.6% in September compared with 100% in August.
- Singleton achieved 100% in September compared with 99.3% in August.
- Princess of Wales Hospital's (POWH) compliance was 98.8%, an increase from 96.1% in August.

What actions are we taking?

- The percentage of patients with a completed NEWS score is kept under regular review by Delivery Unit Quality & Safety Groups.
- The Recognising Acute Deterioration and Resuscitation (RADAR) group is focussing on training staff to use NEWS scores appropriately to recognise deterioration in a patient's condition early so that prompt intervention can take place and also on the recognition and treatment of sepsis.
- Morriston - The Spot the Sick Patient (StSP) Sepsis Programme has been rolled out to all relevant wards and champions identified. Paediatrics, Burns and Cardiac specialties are currently excluded. Education & training has been expanded. Health Care Support Workers (HCSWs) are responding well to training being delivered by HCSW Sepsis Champions. Since May 2017, 1300 staff have received sepsis training.
- NPTH- New alerts stickers to prompt investigations into Acute Kidney Injury, sepsis and general deterioration have been introduced. Since 1st December 2017, every resuscitation trolley in NPTH will have a "Sepsis Bucket", containing what staff need for sepsis screening. As part of 'Spot the Sick Patient' campaign NPTH is undertaking NEWS education at ward level again alongside response/action. Sepsis is included.
- POWH - over the past 20 months, 237 nursing staff and 44 medical staff have received training. The Action for NEWS sticker is working well as a prompt for staff to review patients
- Singleton - Staff training has almost reached 100%. Junior medical staff are strongly engaged with the StSP programme.
- The findings of the recent RRAILS Peer Review will be used to build upon the improvements achieved to date.

What are the main areas of risk?

- Timeliness of rollout given the operational pressures.

How do we compare with our peers?

- No comparable data available.

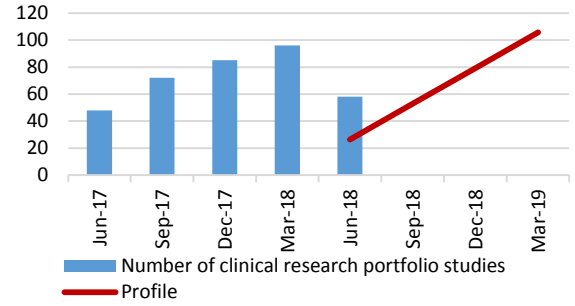
EFFECTIVE CARE - PEOPLE IN WALES RECEIVE THE RIGHT CARE AND SUPPORT AS LOCALLY AS POSSIBLE AND ARE ENABLED TO CONTRIBUTE TO MAKING THAT CARE

Measure 1: Number of Health and Care Research Wales clinical research portfolio studies.
Measure 2: Number of Health and Care Research Wales commercially sponsored studies.
Measure 3: Number of patients recruited in Health and Care Research Wales clinical research portfolio studies.
Measure 4: Number of patients recruited in Health and Care Research Wales commercially sponsored studies.

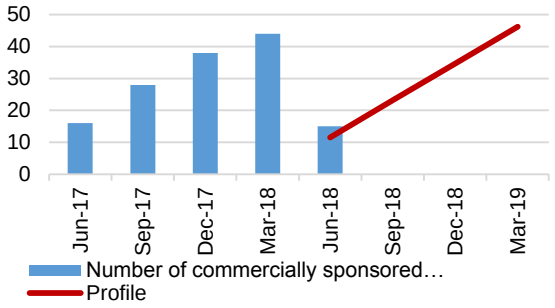
Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			**Executive Lead :** Alastair Roeves Interim Medical Director	
Period : June 2018	**IMTP Profile Target:** (1) 26 (2) 23 (3) 607 (4) 32	**WG Target :** (1), (3) 10% annual improvement (2), (4) 5% annual improvement	**Current Status :** ✓	**Movement :** ↑ Improving

Current Trend: June 17 – Jun 18

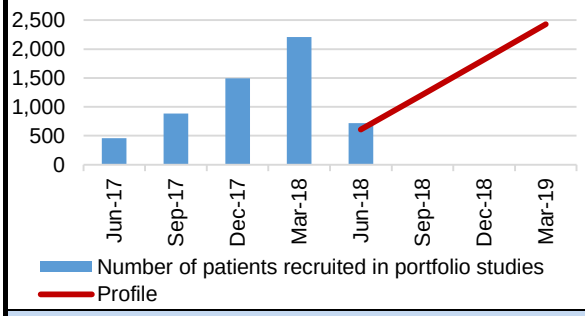
(1) Number of Health and Care Research Wales clinic al research portfolio studies



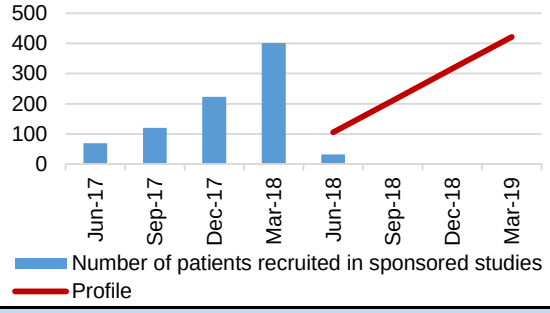
(2) Number of Health and Care Research Wales commercially sponsored studies.



(3) Number of patients recruited in Health and Care Research Wales clinical research portfolio studies.



(4) Number of patients recruited in Health and Care Research Wales commercially sponsored studies.



Benchmarking

LHB	Q1 18-19			
	Measure 1	Measure 2	Measure 3	Measure 4
Wales	218	47	5,923	223
ABM	58	17	721	32
AB	39	5	537	13
BCU	40	7	336	116
C&V	101	16	1,545	42
Ctaf	38	3	1,269	6
HDda	30	2	287	8
Powys	2	0	1,120	0
PHW	2	0	3	0
Velindre	26	4	90	6
WAST	2	0	15	0

Note: As some studies are operating across multiple HBs, the all- Wales figure represents the number of unique studies as opposed to the sum of the HB and Trusts.

Source : NHS WALES OUTCOMES FRAMEWORK, ALL WALES PERFORMANCE SUMMARY (September 2018)

Measure 1: Number of Health and Care Research Wales clinical research portfolio studies.
Measure 2: Number of Health and Care Research Wales commercially sponsored studies.
Measure 3: Number of patients recruited in Health and Care Research Wales clinical research portfolio studies.
Measure 4: Number of patients recruited in Health and Care Research Wales commercially sponsored studies.

How are we doing?

- For measures 1 & 3, we are ahead of where we were at the equivalent quarter last year with 58 studies open & recruiting and 721 patients recruited into portfolio studies – this is 55% and 30% of respective targets achieved. We need to ensure this trend is maintained during the year for the portfolio study targets to be comfortably achieved.
- For measures 2 & 4, relating to number of commercial studies and the number of patients recruited into commercially sponsored studies, we are slightly behind where we were at the same quarter last year with 15 studies open and 32 patients recruiting (compared to 22 studies and 86 patients in 17/18 Q1). Therefore, we are at 32% and 8% of target achieved for measures 2 & 4 respectively.
- The impact of Brexit cannot be ignored as we have seen global pharma choosing not to be place studies in the UK due to the potential pending regulatory system differences however we will continue to use our strengths as UK preferred site and centre of excellence status (JCRF) to continue to open new commercial studies and recruit patients accordingly. The enthusiasm and time commitment of local clinicians to work with pharma will be essential to enable an upward trend.

What actions are we taking?

- Engagement in expressions of interest process led by Health and care Research Wales to identify new portfolio and commercial studies.
- Ensure efficient response times during feasibility and set up to attract Sponsors.
- Effective deployment of research delivery staff to ensure recruitment strategies are maximised.

What are the main areas of risk?

- Impact of UK losing studies in globally competitive environment.
- Slow responses – time for clinicians to respond to expressions of interest and feasibility.

How do we compare with our peers?

- For Q1 18-19 data we are second best performing HB for measure 1 behind Cardiff & Vale.
- Top performing Health Board for measure 2.
- Measure 3 is our area for improvement as we are 4th behind Cardiff & Vale, Cwm Taf and Powys for non-commercial recruits (however the high number of recruits in these Health Boards is likely to be attributed to a particular large scale sample study).
- We are 3rd in Wales for recruiting patients into commercial studies behind Cardiff & Vale and Betsi Cadwaladr Health Boards.

9.4 Dignified Care

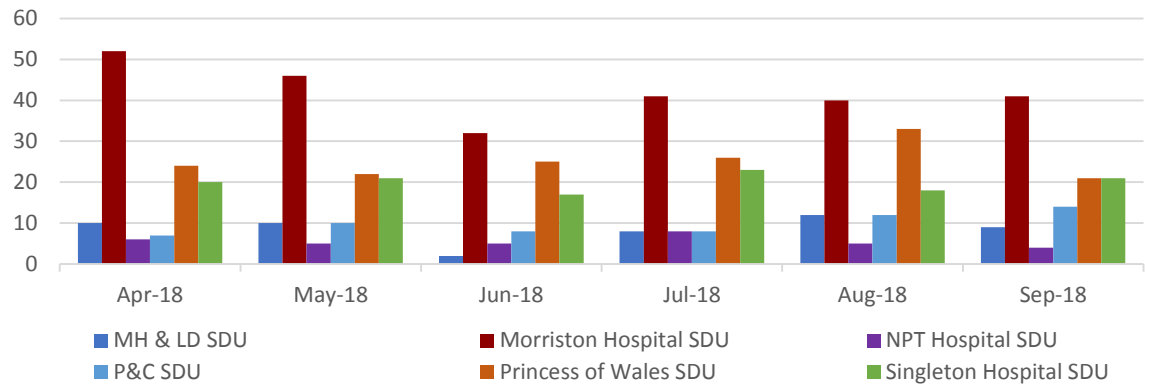
DIGNIFIED CARE: PEOPLE IN WALES ARE TREATED WITH DIGNITY AND RESPECT AND TREAT OTHERS THE SAME

Measure 1: Number of new formal complaints received
Measure 2: % of responses sent within 30 working days
Measure 3: % of acknowledgements sent within 2 working days

Corporate Objective : Embedding Effective Governance and Partnerships			**Executive Lead :** Gareth Howells Director of Nursing & Patient Experience	
Outcome Statement : My voice is heard and listened to				
Period: September 2018	**IMTP Profile Target :** (1) Reduce, (2) 80%	**WG Target :** (1) Monitor, (2) 80%	**Current Status:** ✓	**Movement :** ↑ Improving

Current Trend: (1) Apr 17 – Sep 18 (2) Aug 17 – Aug 18 (3) Sep 17 – Sep 18

(1) Number of new formal complaints received.



(2) % of responses sent within 30 working days

	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18
MH & LD SDU	100%	64%	75%	71%	88%	60%	50%	33%	71%	100%	100%	83%	100%
Morriston Hospital SDU	78%	84%	86%	75%	88%	76%	58%	76%	93%	83%	90%	87%	84%
NPT Hospital SDU	50%	78%	83%	83%	67%	100%	100%	67%	100%	100%	100%	88%	75%
Princess of Wales SDU	81%	68%	67%	62%	64%	93%	60%	74%	75%	90%	64%	90%	88%
P&C SDU	67%	60%	75%	82%	100%	75%	88%	67%	57%	63%	63%	55%	38%
Singleton Hospital SDU	81%	83%	79%	72%	73%	75%	53%	64%	60%	65%	88%	83%	94%
Health Board Total	80%	76%	78%	73%	80%	80%	61%	71%	80%	83%	80%	81%	81%

(3) % of acknowledgements sent within 2 working days

Percentage Acknowledgements Sent ≤ 2 Working Days	2017				2018								
	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Benchmarking

Benchmarking data is not available.

Source : COMPLAINTS MODULE FROM DATIX

Measure 1: Number of new formal complaints received
Measure 2: % of responses sent within 30 working days
Measure 3: % of acknowledgements sent within 2 working days

How are we doing?

- The Health Board received 113 formal complaints in September 2018, this is a decrease of 9 formal complaints compared to 122 for September 2017.
- The overall Health Board response rate for responding to concerns within 30 working days was 81% for August 2018, which is above the Welsh Government target of 80%.
- The Health Board continues to consistently maintain the 2 day acknowledgement target at 100%.
- Patient Advice Liaison Service (PALS) activity for the period April 2018 - August 2018, identified 1,775 contacts of which 2% (37) converted to formalised complaints.

What actions are we taking?

- Performance of the 30 day response target is addressed consistently at all Service Delivery Unit (SDU) performance reviews. August performance for the Health Board was 81%
- Service Delivery Unit's (SDU) identify trends and themes from their formal complaints for discussion at each local Quality and Safety meeting and formal reporting through the Health Boards' Assurance and Learning Group where themes, trends and Health Board actions can be identified and shared for learning. A recurring theme in complaints received continues to be communication. A training programme for communication for all staff grades continues in all SDU's by the Patient Experience Training officer, with further SDU discussions during attendance at Concerns and Redress Group (CRAG)
- Currently there are 43 open Ombudsman investigation cases; Morriston 16, Princess of Wales 10, Singleton 7, Mental Health & Learning Disabilities 3, NPT 2 and ; Primary Care and Community Service 5. Recurring themes from the Ombudsman investigations are discharge process, communication, record keeping and poor complaint handling. The Corporate Concerns function has recently embarked on a re-structure one of the aims of the re structure is to support improvement in the Units and ensure consistency across all of the SDU's in terms of the way the Health Board investigates and responds to complaints. In addition, the Health Board continues to liaise closely with the Ombudsman Improvement Officer and the Community Health Council to discuss on-going investigations. Trends and themes deriving from these interactions will be developed into training and awareness sessions to improve across the Health Board. A new 2018/2019 work plan for Ombudsman referrals has been developed which will be implemented by the newly appointed Ombudsman's Referrals Manager and overseen by the Assistant Head for Concerns Assurance. A key focus on the annual plan will be to demonstrate better learning from the process to help improve future concerns processes.

What are the main areas of risk?

- Improve quality of complaint responses while achieving the 30 day response rate target, and decrease the number of complaints referred to and upheld by the Public Service Ombudsman.

How do we compare with our peers?

- No monthly all-Wales data to compare.

9.5 Timely Care

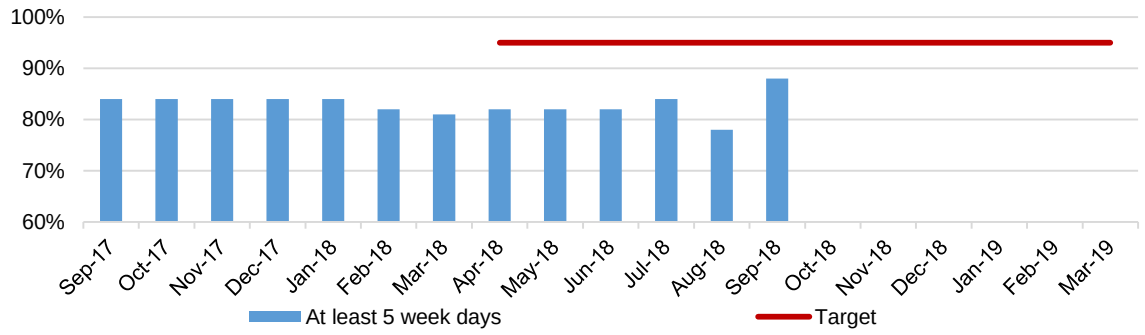
TIMELY CARE - PEOPLE IN WALES HAVE TIMELY ACCESS TO SERVICES BASED ON CLINICAL NEED AND ARE ACTIVELY INVOLVED IN DECISIONS ABOUT THEIR CARE

Measure 1: % GP practices offering appointments between 17:00 & 18:30 at least 5 week days
Measure 2: % GP practices open during the daily core hours or within 1 hour of daily core hours

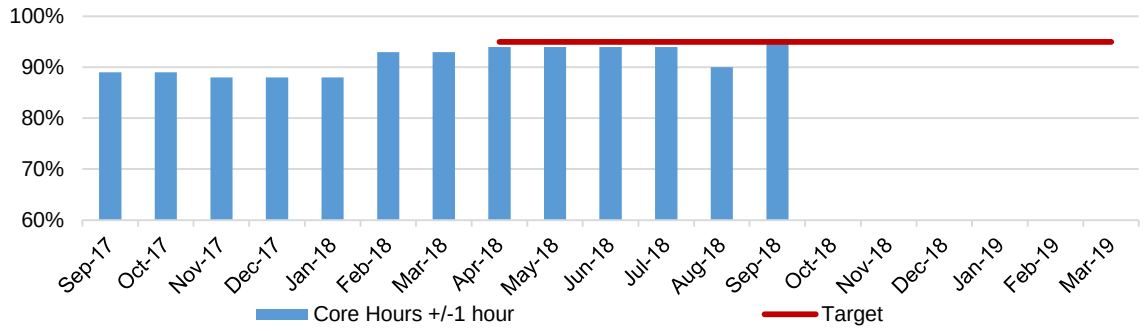
Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			**Executive Lead :** Darren Griffiths Associate Director of Performance	
Outcome Statement : I have easy and timely access to primary care services				
Period : September 2018	**IMTP Profile Target :** (1) 95% (2) 95%	**WG Target :** (1) 95% (2) 95%	**Current Status :** ✗	**Movement :** ↑ Improving

Current Trend: Sep 17 - Sep 18

(1) % GP practices offering appointments between 17:00 & 18:30 at least 5 week days



(2) % GP practices open during the daily core hours or within 1 hour of daily core hours



Benchmarking

LHB	5 days a week					core hours or within 1 hour				
	Current	Previous				Current	Previous			
	2017	2016		2015		2014	2017	2016		2015		2014
Wales	84%	↑	84%	↑	79%	↑ 79%	87%	↑	85%	↑	82%	↑ 80%
ABM	78%	↓	79%	→	78%	↑ 69%	90%	↑	85%	↑	85%	↑ 73%
AB	97%	↓	99%	↑	95%	↑ 93%	99%	↓	99%	↑	93%	↑ 92%
BCU	69%	→	69%	↑	55%	↑ 63%	78%	↑	74%	↑	73%	↑ 73%
C&V	92%	→	92%	↓	94%	↓ 94%	88%	→	88%	↑	83%	↑ 83%
CTaf	95%	↓	95%	↑	93%	↑ 93%	90%	↓	90%	↓	93%	↓ 93%
HDda	80%	↑	75%	↑	65%	↑ 65%	73%	↓	74%	↑	65%	↑ 67%
Powys	100%	→	100%	↑	94%	↑ 94%	100%	→	100%	→	100%	→ 100%

Source : NHS WALES OUTCOMES FRAMEWORK, ALL WALES PERFORMANCE SUMMARY (October 2018)

Measure 1: % GP practices offering appointments between 17:00 & 18:30 at least 5 week days
Measure 2: % GP practices open during the daily core hours or within 1 hour of daily core hours

How are we doing?

- As at September 2018 58/66 (88%) practices are offering appointments between 17.00 and 18.30 at least 5 nights per week. This is an improved position. 63/66 (95%) practices are now open during daily core hours or within 1 hour of daily core hours. This now meets the Welsh Government target and is an improved position.

What actions are we taking?

- The Unit's access and sustainability forum continues to meet with the aim of driving forward improved and sustainable primary care general medical services, the meeting frequency has been increased to bi-monthly. The forum has agreed an access action plan with input from the Community Health Council (CHC) and Local Medical Committee (LMC).
- Five sets of practices have been supported through a discretionary framework to merge, thereby ensuring ongoing access to more sustainable General Medical Services (GMS). Four mergers have been completed and one is due to be completed on the 1st November 2018.
- The primary care team has completed a desk top analysis of current access arrangements by practice and written to all practices who are not meeting the level 1 standards as agreed with the local medical committee.
- This has improved the number of practices meeting minimum standards. The remaining practices are being written to formally again.
- In addition access data has been utilised as one of the criteria to score practices under the GMS governance arrangements is forming part of the visiting programme.
- Clusters continue to be supported to discuss access and sustainability as part of their cluster development plans. This will focus on beginning to introduce the new model of primary care and promote a range of wellbeing services.
- 25% of practices are utilising some form of telephone triage – the telephone first model has been finalised and self-assessment work will take place this year guided by the survey results by March 2019.

What are the main areas of risk?

- Sustainability of general practice will result in poorer access if practices fail or take action to reduce access whilst still being compliant with their contractual requirements.
- Sustainability issues attributed to lack of ability to recruit, retain and poor locum availability.

How do we compare with our peers?

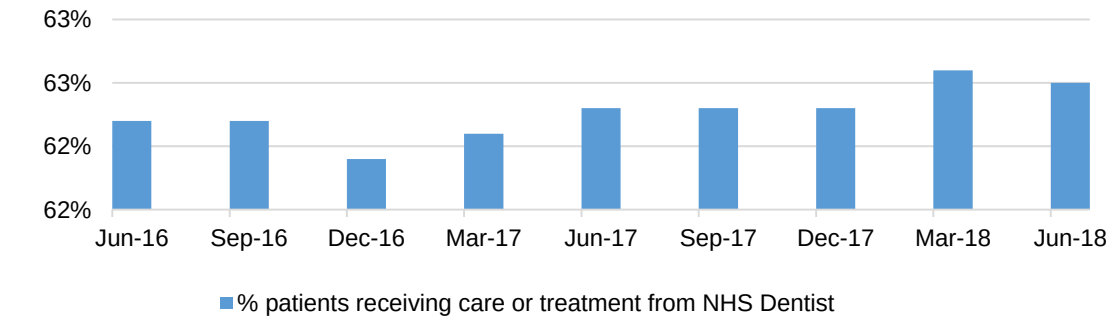
- The access returns were submitted to Welsh Government across Wales in January 2018. The statistical bulletin will provide an updated all Wales picture to benchmark against.

TIMELY CARE - PEOPLE IN WALES HAVE TIMELY ACCESS TO SERVICES BASED ON CLINICAL NEED AND ARE ACTIVELY INVOLVED IN DECISIONS ABOUT THEIR CARE

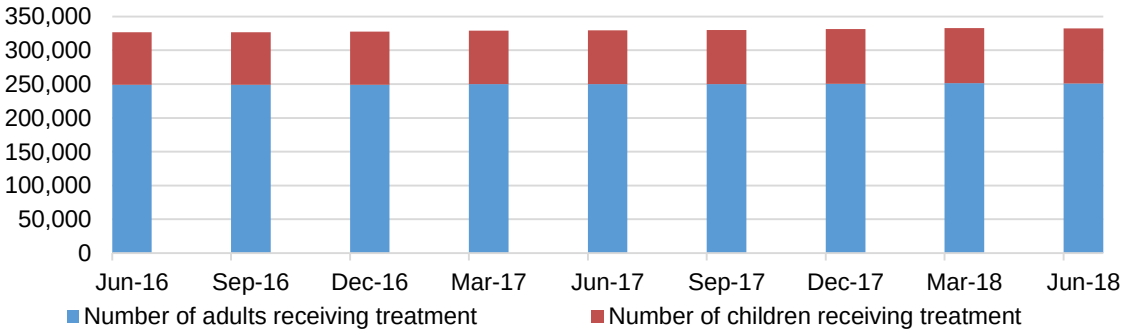
Measure 1: % Patients who received care or treatment from an NHS dentist at least once in the most recent 24 months as a % of the population

Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			**Executive Lead :** Darren Griffiths Associate Director of Performance	
Outcome Statement : I have easy and timely access to primary care services				
Period : March 2018	**IMTP Profile Target :**	**WG Target :** 4 quarter improvement trend	**Current Status :** ✓	**Movement :** ↑ Improving
Current Trend: Jun 16 – Mar-18				

(1) % Patients who received care or treatment from an NHS dentist at least once in the most recent 24 months as a % of the population



Number of Patients receiving NHS treatment



Benchmarking

LHB	Current	Same Period Comparison		
	Mar-18	Mar-17	Mar-16	Mar-15
Wales	55.0%	↑ 54.9%	↑ 54.9%	↑ 54.8%
ABM	62.6%	↑ 62.1%	↑ 62.3%	↑ 62.4%
AB	57.3%	↑ 56.9%	↑ 57.0%	↑ 56.5%
BCU	49.5%	↓ 49.8%	↓ 50.1%	↓ 50.5%
C&V	56.0%	↓ 56.4%	↑ 55.9%	↑ 55.3%
CTaf	59.5%	↑ 58.2%	↑ 57.1%	↑ 57.4%
HDda	45.6%	↓ 46.0%	↓ 45.6%	↑ 45.4%
Powys	57.1%	↓ 57.5%	↓ 59.4%	↓ 60.5%

Source : STATS WALES, Dental Services, NHS Business Services Authority

Measure 1: % Patients who received care or treatment from an NHS dentist at least once in the most recent 24 months as a % of the population

How are we doing?

- The NHSBSA June 2018 data above confirms a steady +0.2% increase in the total number of patients (adults and children) who received NHS dental treatment in ABMU from the previous March: 2.7% more children and 0.3% more adults.
- Demand for routine and urgent dental care services remains high despite the increased service commissioned in November 2017 and April 2018 plus additional urgent access sessions.
- Previous reports advised that a new dental contract for 12,500 UDAs (£300,000) has been commissioned in the Sandfields area of Port Talbot, an area of high deprivation and need. The practice was due to open in December 2018 but due to continued delays to remove the restricted covenant on the building (by the Local Authority), the opening of the much needed NHS practice continues to be delayed. When open (early January 2019 now assumed) it will provide a significant increase to NHS dental care within the local area. The benefits to patients of commissioning the practice as a new dental 'pacesetter' – with no Unit of Dental Activity target (much like ABMU's long-standing two prototypes) is currently being explored.
- High patient demand for access to urgent dental care continues, with the number of patients accessing the In Hours Access Service increasing on an annual basis: 9% from 2016 to 2017. April -Sep'18 data also shows 1% increase of usage compared with the same period in 2017. NB this figure includes repeat visits by patients who choose to access dental care through this service rather than unique individual patient numbers
- Practice year-end figures for 2017/18 confirmed performance against contracted UDA targets:
  * 27% of practices over-performed, achieving >100% of their contracted target.
  * 32% of practices achieved delivered their contract within regulated tolerance level (95-100%)
  * 40% of practices delivered less than 95% of their contracted UDA target and monies reclaimed for the underperformance.

  NB- A number of practices failed to reach their annual UDA target at the end of Mar'18, due to dental practitioner posts remaining vacant for months which had a negative impact on year end achievement.
- General Dental Practitioner (GDP) Fellowship scheme commenced in October 2018: a 3yr scheme to train a Fellow in Endodontics to work in primary care. Ultimately this will support the reduction of referrals to Restorative Dentistry, reducing waiting times and free two sessions within the fellow's host practice to broaden the dental team skill mix, enabling the practice to offer more access to preventative advice and treatment to patients via Oral Health Educators and Dental Hygienist.

What actions are we taking?

- Supporting the new practice, engaging with the Local Authority to secure the removal of the restricted covenant to expedite the development of the new practice.
- Signposting/encouraging patients to use mainstream dental service rather than making unnecessary use of the urgent care services to ensure the latter can focus on those who need it
- Providing more in-hours access sessions through the Educational Supervisors at the Dental Teaching Unit, maintaining their clinical skills and increasing access to NHS dental care.
- Extending the paediatric GA pathway for routine referrals to include urgent care in November 2018.
- Supporting general practice bids for additional Welsh Government funds (via a new Innovation Fund), to improve skill-mix within dental teams and develop new pathways of care for patients to access GDS services in line with GDS reform programme.
- Monitoring compliance against the quality indicators with those practices (43) who received a performance based UDA uplift: the scheme should secure improved access over a 2 year period.
- Commence (October) the Mid-Year contract review process; reallocating funds from practices that recurrently underperform to reinvest into alternative services.
- Reviewing GDS/CDS domiciliary services to inform planned development of a new integrated model to ensure more housebound patients receive oral health care treatment.

What are the main areas of risk?

- Continued delays in the new practice opening in Port Talbot.

How do we compare with our peers?

- ABMU Health Board continues to maintain its positon as provider to the highest percentage of patients receiving dental care compared to all other Health Boards and is significantly higher than the all-Wales average. GDP Fellowship is unique to ABMU Health Board.

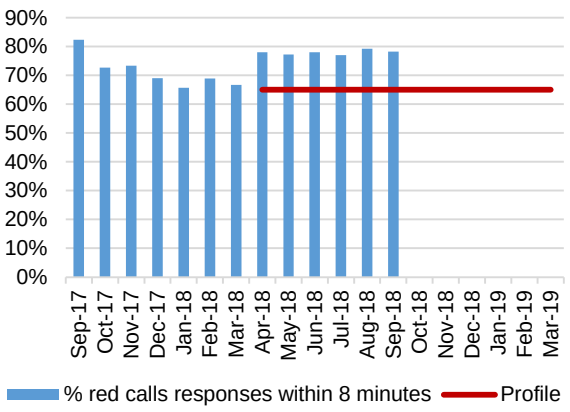
TIMELY CARE - PEOPLE IN WALES HAVE TIMELY ACCESS TO SERVICES BASED ON CLINICAL NEED AND ARE ACTIVELY INVOLVED IN DECISIONS ABOUT THEIR CARE

Measure 1: % of emergency responses to red calls arriving within (up to and including) 8 minutes
Measure 2: Number of patients waiting more than 1 hour for an ambulance handover

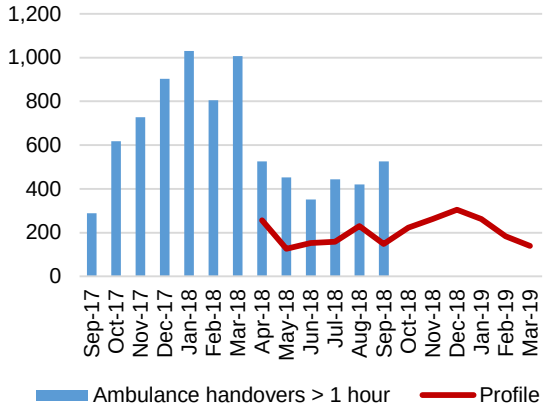
Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			**Executive Lead :** Darren Griffiths Associate Director of Performance	
Outcome Statement : To ensure the best possible outcome, my condition is diagnosed early and treated in accordance with clinical need				
Period : September 2018	**IMTP Profile Target :** (1)65% (2)149	**WG Target :** (1)65% (2) 0	**Current Status :** ✗	**Movement :** ↑ ● Improving

Current Trend: Sep 17 - Sep 18

(1) % of emergency responses to red calls arriving within (up to and including) 8 minutes

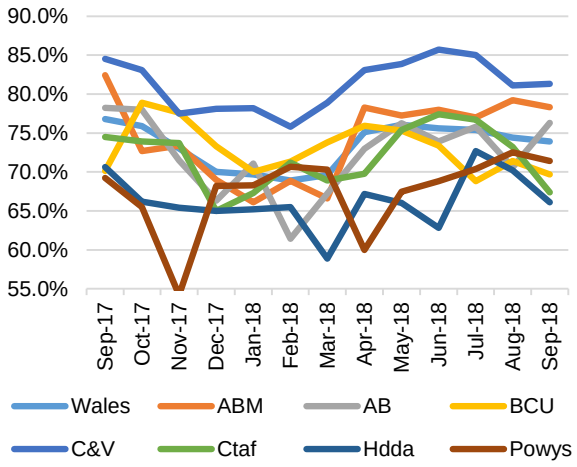


(2) Number of patients waiting more than 1 hour for an ambulance handover

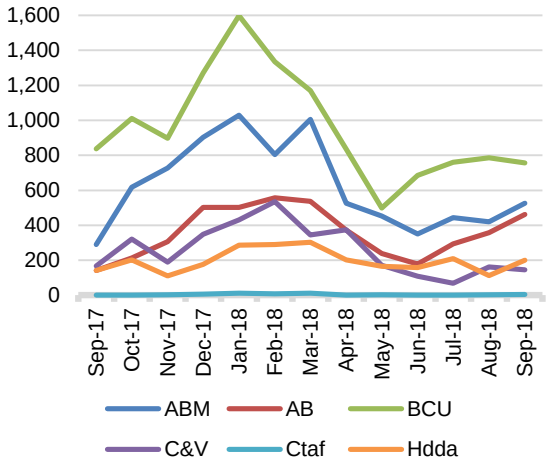


Benchmarking

(1) % of emergency responses to red calls arriving within (up to and including) 8 minutes



(2) Number of patients waiting more than 1 hour for an ambulance handover



Source : NHS WALES DELIVERY FRAMEWORK, ALL WALES PERFORMANCE SUMMARY (October 2018)

Measure 1: % of emergency responses to red calls arriving within (up to and including) 8 minutes
Measure 2: Number of patients waiting more than 1 hour for an ambulance handover

How are we doing?

- The Health Board's Category A (Red response) was 78.3% in September 2018, which exceeded the National shared target of 65%.
- 1 hour ambulance handover performance has deteriorated during Quarter 2 from 368 patients reported in June to 541 patients reported in September.
- 273 less patients (a 7.6% reduction) were conveyed to our hospital front doors by ambulance in September 2018 when compared with September 2017. This is a reflection of the joint work programme which is in place between the Health Board and Welsh Ambulances Service NHS Trust (WAST) to reduce conveyance rates to hospital by an emergency ambulance.

What actions are we taking?

- The Health Board is working closely with WAST to ensure that patients are directed to the most appropriate service or pathway of care that best meets their needs and as a result the number of patients conveyed to hospital by ambulance is reducing (7.6% less conveyances in September 2018 compared with 2017).
- Continued development of pathways, models of care and the workforce within available resources to reduce health care professional requests for an emergency ambulance response. There was an 8.7% reduction in the green/HCP call conveyance category in September 2018 when compared with September 2017.
- Implementation of the management recommendations provided in response to the WAST internal audit report on hospital handover. A progress update was provided to the USC board in October 2018, and the majority of recommendations applicable to ABMU HB have been implemented in line with the agreed plan.
- The Health Board has funded paramedic posts in the out of hours service which will enable 24/7 paramedic cover to be provided to assist and support this service from 5th November 2018.

What are the main areas of risk?

- Ambulance resourcing to respond to demand within the 8 minute response time.
- Hospital and social care system wide flow constraints which impact upon the Emergency Department's ability to receive timely handover. This can result in increased risk to patients in the community and at hospital if there are prolonged ambulance handover times.

How do we compare with our peers?

- The Health Board delivered the 2nd highest Category A response time performance in Wales in September, achieving 78.3% against the all-Wales performance of 73.5%.
- The Health Board continues to experience a higher number of delays than the majority of other Health Boards in Wales.

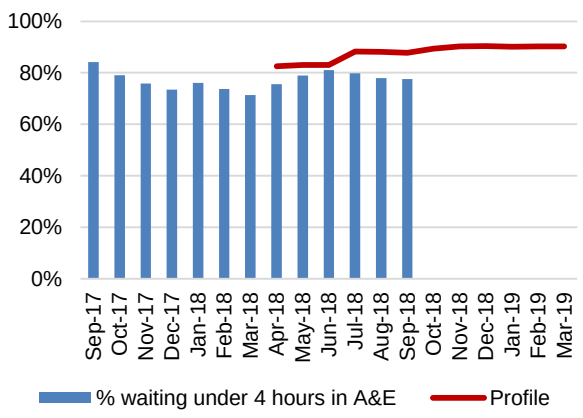
TIMELY CARE - PEOPLE IN WALES HAVE TIMELY ACCESS TO SERVICES BASED ON CLINICAL NEED AND ARE ACTIVELY INVOLVED IN DECISIONS ABOUT THEIR CARE

Measure 1: % new patients spending no longer than 4 hours in an Emergency Department
Measure 2: Number of patients spending more than or equal to 12 hours in A&E

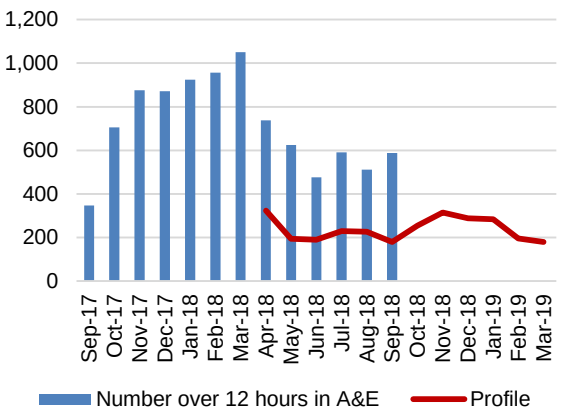
Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			**Executive Lead :** Darren Griffiths Associate Director of Performance	
Outcome Statement : To ensure the best possible outcome, my condition is diagnosed early and treated in accordance with clinical need				
Period : September 2018	**IMTP Profile Target :** (1) 87.8% (2) 180	**WG Target :** (1) 95% (2) 0	**Current Status :** ✗	**Movement :** ↑ Improving

Current Trend: Sep 17- Sep 18

(1) % new patients spending no longer than 4 hours in an Emergency Department

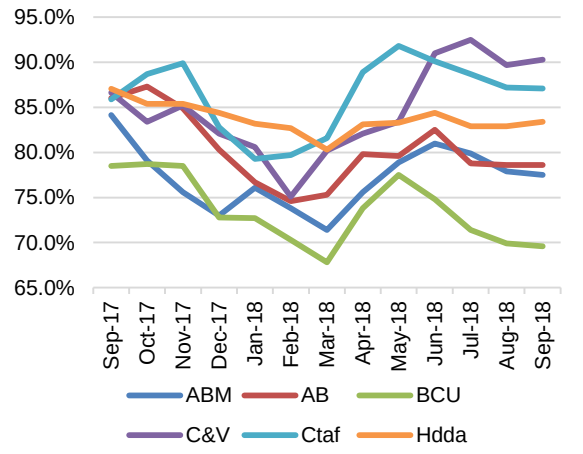


(2) Number of patients spending more than or equal to 12 hours in A&E

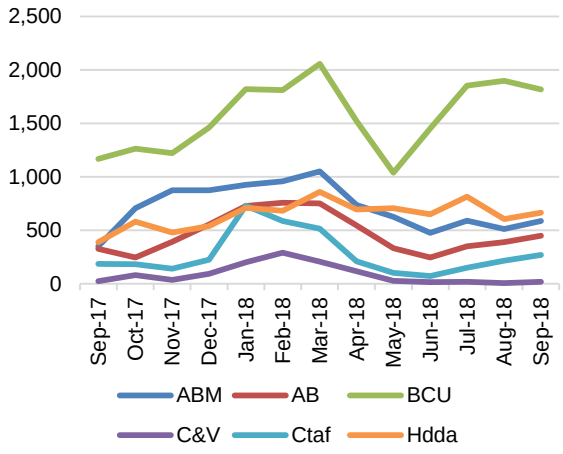


Benchmarking

(1) % new patients spending no longer than 4 hours in an Emergency Department



(2) Number of patients spending more than or equal to 12 hours in A&E



Source : NHS WALES OUTCOMES FRAMEWORK, ALL WALES PERFORMANCE SUMMARY (October 2018)

Measure 1: % new patients spending no longer than 4 hours in an Emergency Department
Measure 2: Number of patients spending more than or equal to 12 hours in A&E

How are we doing?

- Unscheduled care performance against the 4 hour target in September 2018 was 77.5%, against the all-Wales performance of 80.3%.
- In September 2018, 96.1% of patients were admitted, discharged or transferred from our Emergency Departments within 12 hours. However, 588 patients stayed over 12 hours in our Emergency Departments during September 2018 which represented a 15% increase when compared with August and a 69% increase when compared with September 2017.
- The overall number of patients attending the Emergency Departments and minor injuries units in September 2018 reduced by 623 attendances or 4% compared with September 2017.

What actions are we taking?

- Implementation of Quarter 3 unscheduled care improvement plans with a specific focus on:
  - Implementation of GP expected pathways and improved access to speciality services with additional hot clinics (Morriston).
  - Embedding the safety huddle approach which will strengthen daily patient flow processes (Morriston).
  - Expand the opening hours of the medical day unit in Singleton and fully implement the integrated older person's service model at this hospital.
  - Systematic focus on improving the minor's workstream in the ED at Princess of Wales hospital.
  - Developing the early supported discharge service which commenced in Neath Port Talbot hospital (NPT) in mid-September.
- Implementation of our winter assurance plan for 2018/19.
- Reviewing our discharge improvement programme of work in light of feedback recently received from the Delivery Unit's complex discharge audit which was undertaken in August. This feedback will also be considered alongside the findings of the inpatient bed utilisation survey which was undertaken in Swansea and NPT hospitals in early October.

What are the main areas of risk?

- Capacity gaps in Care Homes, Community Resource Teams and capacity and fragility of private domiciliary care providers, leading to an increase in the number of patients in hospital who are 'discharge fit'.
- Workforce - with ongoing challenges in general nursing and medical roles in some key specialities and service areas such as the Emergency Department (ED).
- Peaks in demand/patient acuity above predicted levels of activity.
- The impact of infection on available capacity and patient flow.

How do we compare with our peers?

- The Health Board's 4 hour performance was 77.5% in September 2018, which was below the all-Wales 4 hour performance of 80.3% for this period.
- In ABMU Health Board, 96.1% of all patients were assessed, treated and transferred from the Emergency Department within 12 hours in the month of September, which was above the all-Wales position of 95.6%.

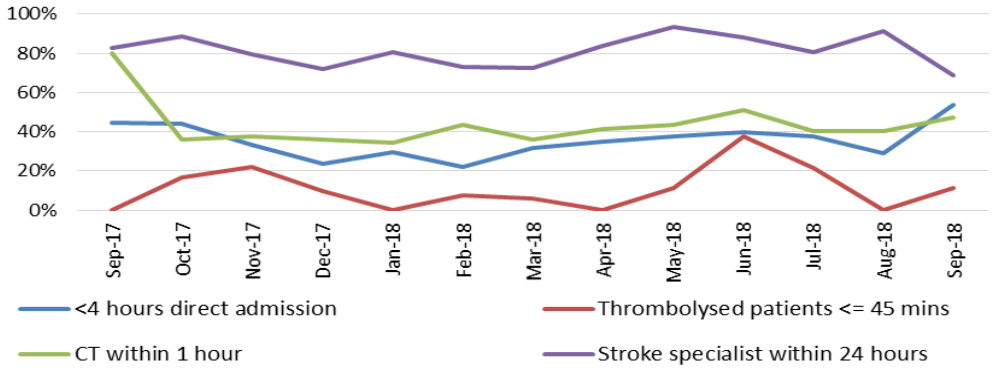
TIMELY CARE - PEOPLE IN WALES HAVE TIMELY ACCESS TO SERVICES BASED ON CLINICAL NEED AND ARE ACTIVELY INVOLVED IN DECISIONS ABOUT THEIR CARE

Measure 1: % of patients who have a direct admission to an acute stroke unit within 4 hours
Measure 2: % of thrombolysed stroke patients with a door to door needle time of less than or equal to 45 minutes
Measure 3: % of patients who receive a CT scan within 1 hour
Measure 4: % of patients who are assessed by a stroke specialist consultant physician within 24 hours

Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			**Executive Lead :** Darren Griffiths Associate Director of Performance	
Outcome Statement : To ensure the best possible outcome, my condition is diagnosed early and treated in accordance with clinical need				
Period : September 2018	**IMTP Profile Target :** (1)50% (2)30% (3)45% (4)80%	**WG Target :** (1) 59.7% (2)12 month improvement trend (3) 54.4% (4) 84%	**Current Status :** ✗	**Movement :** ↑ Improving

Current Trend: Sep 17 - Sep 18

Acute Stroke Quality Improvement Measures



Benchmarking

Thrombolysis Quality Improvement Measures	AB	ABM	BCU	C&V	Cwm Taf	Hywel Dda
1a - Percentage of All Strokes Thrombolsyed - H16.3	7.1%	11.3%	17.2%	13.5%	13.5%	8.5%
2b - Percentage of Eligible Patients Thrombolsyed - H16.55	100.0%	100.0%	87.5%	100.0%	71.4%	100.0%
1a - Thrombolysed Patients with Door-to-Needle <= 30 mins	25.0%	0.0%	6.7%	14.3%	14.3%	0.0%
2b - Thrombolysed Patients with Door-to-Needle <= 45 mins	50.0%	11.1%	20.0%	14.3%	42.9%	60.0%
3c - Thrombolysed Patients with Onset to-Needle <= 90 mins	0.0%	11.1%	13.3%	0.0%	0.0%	0.0%
4d - Thrombolysed Patients with Pre and Post Thrombo NIHSS Score	75.0%	100.0%	100.0%	100.0%	85.7%	100.0%
72 Hour Pathway Quality Improvement Measures	**AB**	**ABM**	**BCU**	**C&V**	**Cwm Taf**	**Hywel Dda**
1. < 4 Hours Care Performance Indicator	35.7%	53.8%	44.8%	50.0%	51.9%	74.6%
1a - Direct Admission to Acute Stroke Unit - H7.18	37.5%	53.8%	45.3%	60.8%	51.9%	71.7%
1b - Swallow Screening - H14.20	72.7%	88.3%	87.5%	65.3%	92.3%	96.0%
2. < 12 Hours Care Performance Indicator	98.2%	96.3%	93.1%	98.1%	96.2%	98.3%
2a - CT Scan - H6.12	98.2%	96.3%	93.1%	98.1%	96.2%	98.3%
3. < 24 Hours Care Performance Indicator	82.1%	65.0%	88.5%	88.5%	67.3%	96.6%
3a - Assessed by Stroke Consultant - H9.3	96.4%	68.8%	89.7%	92.3%	78.8%	98.3%
3b - Assessed by Stroke Nurse - H8.3	96.4%	97.5%	98.9%	96.2%	96.2%	100.0%
3c - Assessed by One of OT, PT, SALT	82.1%	95.0%	97.7%	92.3%	86.5%	98.3%
4. < 72 Hours Care Performance Indicators	92.9%	98.8%	94.3%	90.4%	96.2%	94.9%
4a - Formal Swallow Assessment - H15.24	100.0%	100.0%	96.8%	88.5%	93.3%	94.1%
4b - OT Assessment - H10.24	92.5%	98.5%	100.0%	91.8%	100.0%	95.7%
4d - SALT Communication Assessment - H12.24	100.0%	100.0%	98.8%	95.9%	98.0%	100.0%
5. < 1 Hour Care Performance Indicator	53.6%	47.5%	43.7%	57.7%	67.3%	78.0%
5a - CT Scan	53.6%	47.5%	43.7%	57.7%	67.3%	78.0%

>= Target | Within 10% below target | More than 10% below taget

Source : ALL WALES PERFORMANCE SUMMARY (SEPTEMBER 2018) + ACUTE STROKE QUALITY IMPROVEMENT MEASURES DU REPORT

Measure 1: % of patients who have a direct admission to an acute stroke unit within 4 hours
Measure 2: % of thrombolysed stroke patients with a door to door needle time of less than or equal to 45 minutes
Measure 3: % of patients who receive a CT scan within 1 hour
Measure 4: % of patients who are assessed by a stroke specialist consultant within 24 hours

How are we doing?

- Over the last 4 weeks – Eligible Patients requiring Thrombolysis has remained positive and direct admissions to a stroke unit bed within 4 hours improved in Morriston with 78.8% - but deteriorated in Princess of Wales Hospital (POWH) to 28.1%. Assessment by a Consultant was 84.6% in Morriston, and 59.4% in POW. CT scanning within 12 hours improved to 98.1% in Morriston and 93.8% in POWH.
- Door to Needle time requires further review but is expected to improve with the additional appointments in medical staffing.
- Additional Medical appointments have taken up post during August and September – although there remain gaps in overall out of hours cover.

What actions are we taking?

- Weekly multi-disciplinary meetings are held in Morriston and POWH to review individual patient pathways and to identify opportunities for improvement. Actions being progressed in Quarter 3 include:

Morriston

- The additional medical staffing will allow 2 registrars being on duty from 10pm-9:30am Midweek – and on Weekends there will be 2 registrars providing cover from 9am -2:00am the next morning. One registrar focuses on the ward cover and the other provides a presence in A&E for all number of conditions but including Stroke. When there are two middle grades on a night shift or weekends, it is proposed that one of them is nominated as the stroke champion. Discussions on the Thrombolysis Champion role amongst the medical Out Of Hours team are underway and scheduled to be completed by the end of November.
- A business case for a Stroke Retrieval team to be considered by local management team once completed, and then included within the IMTP / IBG for investment.
- Swallow screening training with ED staff has been completed with the aim to improve the response/ performance and quality of service to patients with a potential stroke. Monitoring of this will be reflected in the monthly reports.

Princess of Wales

- The five Task and Finish groups continue to undertake actions to improve their performance
- Clerking procedures in ED have changed with patient transfers now not being delayed because of clerking arrangements – where necessary clerking is undertaking on the ward and the patient transferred in a more timely fashion. Performance in accessing a Stroke bed should therefore improve and not delayed because they were awaiting a clerking in procedure to be completed in ED.
- The Unit is developing a case for an early Supported Discharge service.

ABMU wide

- Ongoing planning in terms of working towards the “Hyper-acute Stroke Unit” model. Non recurrent funding secured from national funding to fund a dedicated project manager to support this work. Appointment has been made and the successful applicant has started.
- The Morriston Business case for an ESD has been considered by the IBG – with further work required and alternate sources of funding – non recurrent and recurrent being considered

What are the main areas of risk?

- Insufficient capacity and workforce resilience to support 7 day working which will ultimately require a strategic change to centralise acute stroke services.
- Unscheduled care pressures and increasing waits for transfers of care affecting stroke care capacity.

How do we compare with our peers?

- Performance against the 4 hour bundle continued to be the main challenge for ABMU Health Board. The Health Board thrombolysis rates for eligible patients were amongst the highest, Access to specialist assessment within 24 hours compares well with the majority of Health Boards. CT scanning time within 1 hour is improving but requires further work to match the best performing Health Board's – Morriston improved to 57.7% and POWH to 40.6% over the 4 weeks ending the 5th October.

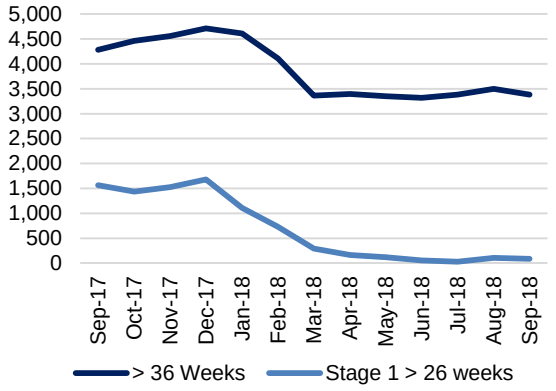
TIMELY CARE - PEOPLE IN WALES HAVE TIMELY ACCESS TO SERVICES BASED ON CLINICAL NEED AND ARE ACTIVELY INVOLVED IN DECISIONS ABOUT THEIR CARE

Measure 1: Number of patients waiting more than 36 weeks for referral to treatment (RTT)
Measure 2: Number of patients waiting more than 26 weeks for first OP appointment
Measure 3: % patients waiting less than 26 weeks for referral to treatment (RTT)

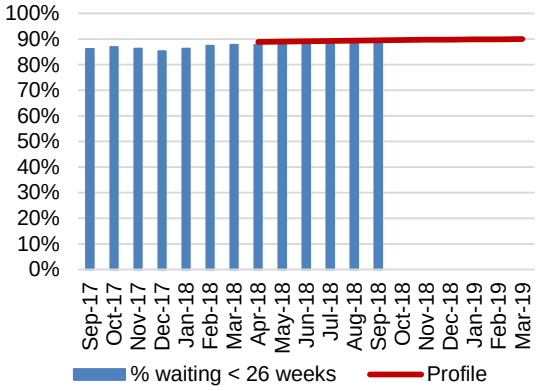
Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			**Executive Lead :** Darren Griffiths Associate Director of Performance	
Outcome Statement : To ensure the best possible outcome, my condition is diagnosed early and treated in accordance with clinical need				
Period : September 2018	**IMTP Profile Target :** (1) 3,067 (2) 0 (3) 89.6%	**WG Target :** (1) 0 (2) 0 (3) 95%	**Current Status :** ✗	**Movement:** ↓ ● Improving

Current Trend: Sep 17 - Sep 18

(1) Number of patients waiting more than 36weeks for referral to treatment, (2) Number of patients waiting more than 26 weeks for first OP appointment

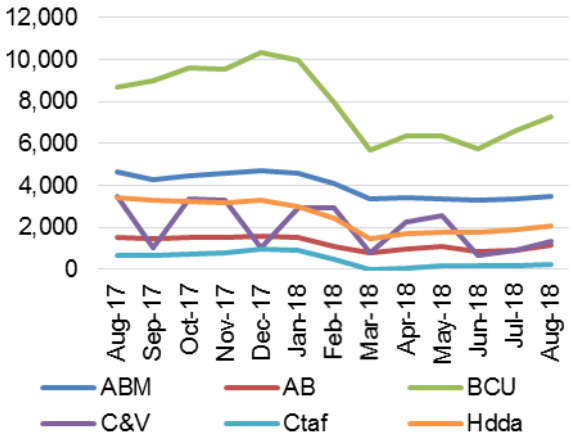


(2) % patients waiting less than 26 weeks for referral to treatment (RTT)

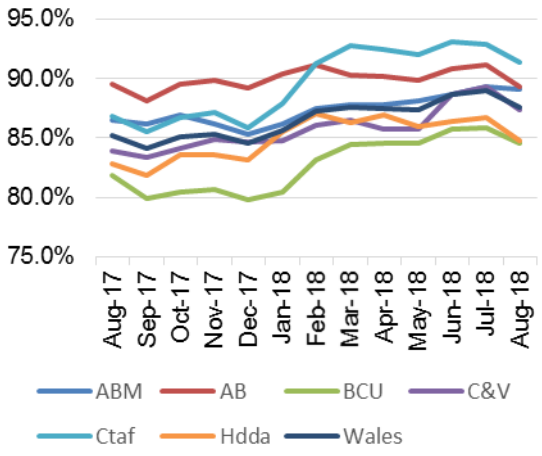


Benchmarking

(1) Number of patients waiting more than 36 weeks for referral to treatment



(3) % patients waiting less than 26 weeks for referral to treatment (RTT)



Source : StatsWales (data extracted 18.10.2018)

Measure 1: Number of patients waiting more than 36 weeks for referral to treatment (RTT)
Measure 2: Number of patients waiting more than 26 weeks for first OP appointment
Measure 3: % patients waiting less than 26 weeks for referral to treatment (RTT)

How are we doing?

- In September 2018 there are 89 patients waiting over 26 weeks for a new outpatient appointment. This was an in-month reduction of 16 compared with August 2018 (105 to 89) and is mainly contained within Ophthalmology (58%).
- There are 3,381 patients waiting over 36 weeks for treatment in September 2018 compared with 4,284 in September 2017, this is an improvement of 903. There was also an in-month reduction of 116 compared with August 2018. ENT, General Surgery, Oral/ Maxillo Facial (OMF) and Orthopaedics collectively account for 3,088 of the 3,381 over 36 weeks at September 2018. 97% of the patients waiting over 36 weeks are in the treatment stage of their pathway.
- 1,497 patients are waiting over 52 weeks in September 2018 which is 9% less than in September 2017 and 1% less patients than August 2018.
- The overall Health Board RTT target remained stable in September 2018 at 89.1%.

What actions are we taking?

The focus at the weekly RTT meetings is now on Quarter 3 delivery. In addition to the solutions identified within Unit plans to deliver the end of December position, a range of additional actions to address the deteriorating orthopaedic position across both Morriston and the Princess of Wales have been agreed and are being progressed. A high level summary of these include:-

Morriston

- Agreement for outsourcing a further 200 orthopaedic cases in addition to the 200 cases within the RTT delivery plans. Capacity has been secured and outsourcing has commenced.
- A solution to satisfy fire safety compliance for a mobile staffed theatre unit adjoining the hospital corridor from a located court yard has been found. Minor ground works are required and the installation of sprinkler systems into the theatre unit are underway. Final discussions are taking place and the lead in time confirmed so that a start date can be confirmed by the end of November.
- List established at NPTH for two joints per week commencing 19th November, with potential to increase.
- Training to increase the number of theatre scrub staff in readiness to commence from November.

POW

- Paper to Executive Team to consider a time-limited enhanced remuneration system for Orthopaedic theatre nursing staff to enable additional working outside core hours.
- Discussions with Cwm Taf regarding their offer to backfill lists are concluding. The outcome will be known by the end of October and if feasible start dates to be agreed.

What are the main areas of risk?

- Lack of theatre and staff availability to provide extra capacity for evening and weekend clinics/lists.
- Administrative vacancy gaps and sickness impacting on ability to target robust validation.
- Staff fatigue to continue to run additional clinics and lists.
- Demand of cancer and urgent surgical cases utilising planned routine elective capacity and protecting elective bed capacity.
- The current planned care trajectories assume no impact on planned care performance of bed reconfiguration within the Health Board (i.e. the planned length of stay reductions and alternative care models deliver a zero net bed impact).

How do we compare with our peers?

- As at the end of September 2018, which is the latest published data available, ABMU was above the all-Wales position for the percentage of patients waiting less than 26 weeks for referral to treatment (RTT) (89.1% compared with 87.6%) however, was the second worst Health Board in Wales for the number of patients waiting over 36 weeks.

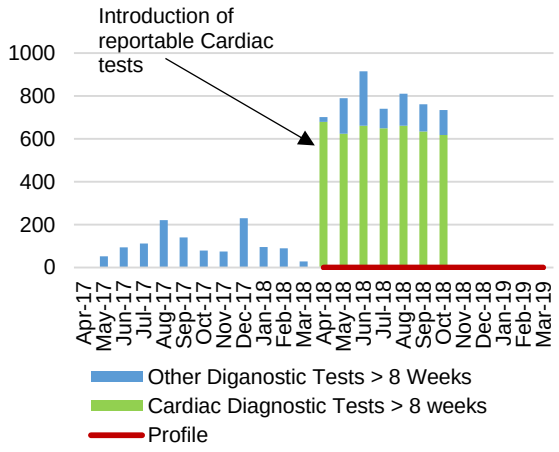
TIMELY CARE - PEOPLE IN WALES HAVE TIMELY ACCESS TO SERVICES BASED ON CLINICAL NEED AND ARE ACTIVELY INVOLVED IN DECISIONS ABOUT THEIR CARE

Measure 1: Number of patients waiting more than 8 weeks for specific diagnostics (excluding Endoscopy)
Measure 2: % patients waiting less than 8 weeks for specific diagnostics (excluding Endoscopy)

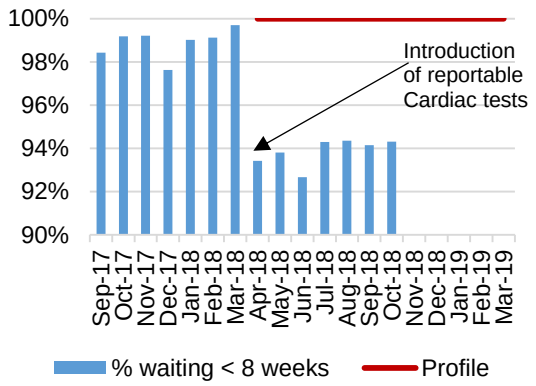
Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			**Executive Lead :** Darren Griffiths Associate Director of Performance	
Outcome Statement : To ensure the best possible outcome, my condition is diagnosed early and treated in accordance with clinical need				
Period : September 2018	**IMTP Profile Target :** (1) 0 (2) 100%	**WG Target :** (1) 0 (2) 100%	**Current Status :** ✗	**Movement :** ↑ ● Worsening

Current Trend: Sep 17 - Sep 18

Measure 1: Number of patients waiting more than 8 weeks for specific diagnostics (excluding Endoscopy)

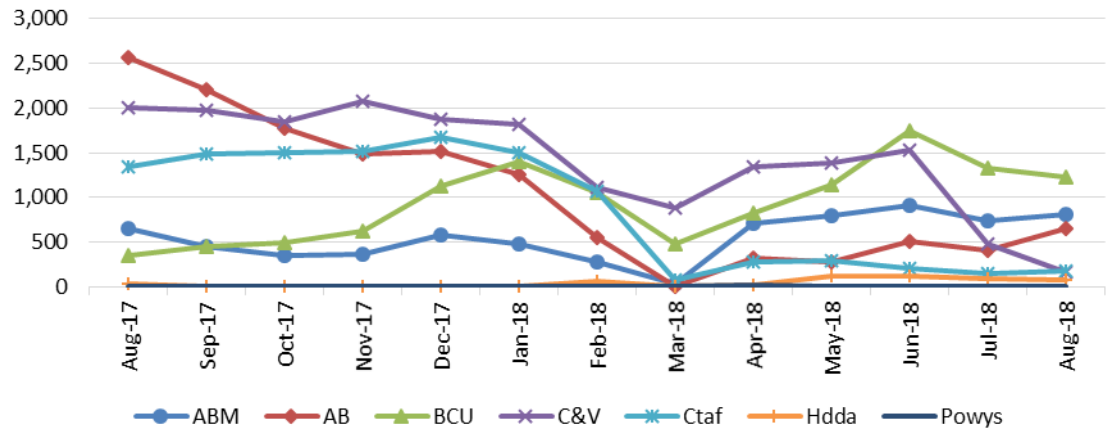


Measure 2: % patients waiting less than 8 weeks for specific diagnostics (excluding Endoscopy



Benchmarking

Measure 1: Number of patients waiting more than 8 weeks for specific diagnostics (excluding Endoscopy)



Source : StatsWales (extracted data 18.10.2018)

Measure 1: Number of patients waiting more than 8 weeks for specific diagnostics (excluding Endoscopy)
Measure 2: % patients waiting less than 8 weeks for specific diagnostics (excluding Endoscopy)

How are we doing?

- There were 762 patients waiting over 8 weeks for reportable diagnostics as at the end of September 2018. 123 breaches are for Non-Obstetric Ultrasounds (NOUS) and 4 breaches for Cystoscopy in Princess of Wales Hospital. The remaining 635 breaches are for the additional Cardiac tests which have been made reportable since April 2018. The reporting of additional tests is intended to provide insight into delays for specific tests that have an impact on overall Cardiac Referral to Treatment Times. The breakdown for patients waiting over 8 weeks for Cardiac Tests in June 2018 is as follows:
  - Diagnostic Electrophysiology (EP Study)= 1
  - Diagnostic Angiography = 33
  - Cardiac Magnetic Resonance Imaging (Cardiac MRI)= 209
  - Cardiac Computed Tomography (Cardiac CT)= 392
- All other diagnostic areas maintained a zero breach position in March 2018.

What actions are we taking?

- The 123 NOUS patients at the end of September are as a result of continued reduced workforce capacity amongst the Head & Neck sub-specialty Radiologists and Sonographers. Recent analysis undertaken is showing a growth in demand for total ultrasounds of 30 per week. Further analysis is underway to break this down to the sub-speciality of Neck and referral patterns to address potential hot spots. This work will conclude and be shared by the end of October. Outsourcing is in place to improve the breach numbers.
- There is an ongoing handful of Cystoscopy breaches in Princess of Wales as a result of significant sickness absenteeism amongst the small consultant body. Locum consultants continue to be sourced and appointed however retaining these personnel is proving challenging. Discussions with Cwm Taf University Health Board are taking place to scope potential to support the Urology service.
- A case for a Health Board wide solution for Cardiac CT and MRI has been submitted. The plan requires scrutiny and testing through the October RTT meeting prior to a decision on its implementation.
- The suite of newly reportable cardiology diagnostics (excluding Cardiac CT and MRI) will clear at the end of Quarter 3 and be sustained.

What are the main areas of risk?

- Routine activity being displaced by urgent and cancer patients. This is a particular risk for the Urology diagnostic procedures at Princess of Wales Unit due to the fragility of their service.
- Late clinic cancellations due to unforeseen absence of key clinical staff.
- Breakdown of equipment.
- Workforce constraints in key professional groups (nationally and locally).

How do we compare with our peers?

- At the end of August 2018, which is the latest published data available at the time of writing this report, ABMU was the second worst performing Health Board excluding Powys.

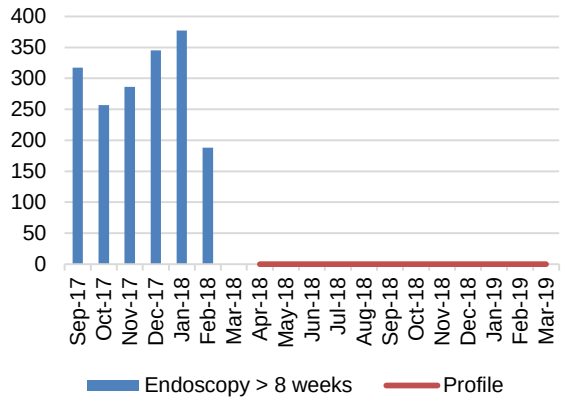
TIMELY CARE - PEOPLE IN WALES HAVE TIMELY ACCESS TO SERVICES BASED ON CLINICAL NEED AND ARE ACTIVELY INVOLVED IN DECISIONS ABOUT THEIR CARE

Measure 1: Number of patients waiting more than 8 weeks for Endoscopy
Measure 2: % patients waiting less than 8 weeks for Endoscopy

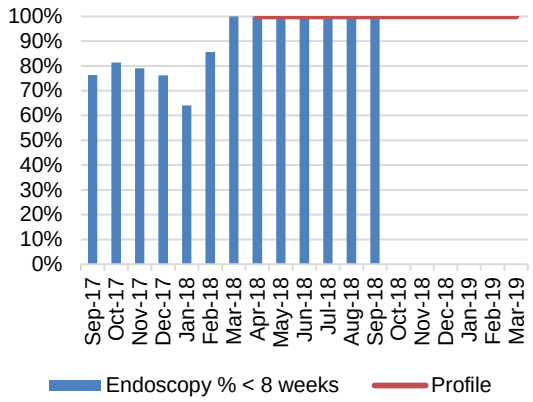
Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			**Executive Lead :** Darren Griffiths Associate Director of Performance	
Outcome Statement : To ensure the best possible outcome, my condition is diagnosed early and treated in accordance with clinical need				
Period : September 2018	**IMTP Profile Target :** (1) 0 (2) 100%	**WG Target :** (1) 0 (2) 100%	**Current Status :** ✓	**Movement :** ↓ Improving

Current Trend: Sep 17 - Sep 18

(1) Number of patients waiting more than 8 weeks for Endoscopy

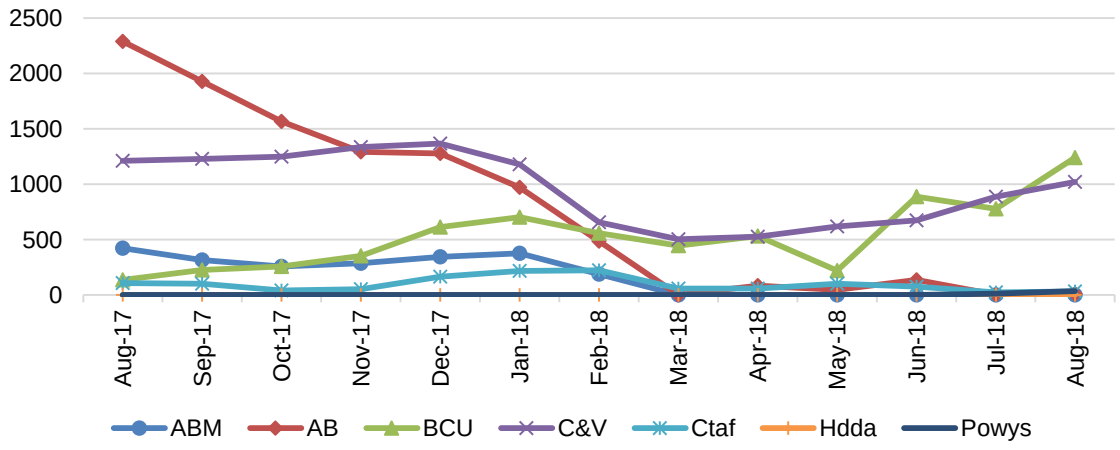


(2) % patients waiting less than 8 weeks for Endoscopy



Benchmarking

(1) Number of patients waiting more than 8 weeks for Endoscopy



Source : NHS WALES OUTCOMES FRAMEWORK, ALL WALES PERFORMANCE SUMMARY (October 2018)

Measure 1: Number of patients waiting more than 8 weeks for Endoscopy
Measure 2: % patients waiting less than 8 weeks for Endoscopy

How are we doing?

- ABMU Health Board has achieved zero position for patients waiting over 8 weeks for endoscopy as of the end of October 2018 and we are currently reporting at 6 weeks.
- Endoscopy continues to see a significant increase in urgent suspected cancer referrals. The majority of these continue to be in the area of Lower Gastroenterology referrals internally from surgical specialties.
- Did not Attend (DNA) rates continue to remain low at 3%.

What actions are we taking?

- Utilising all available capacity with an average of 30 backfill lists being undertaken per month across 2 sites - current agreement for funding until end of October 2018.
- Working closely with colleagues in the NHS Wales Delivery Unit to review demand and capacity plans and ongoing review weekly to ensure that capacity is being maximised on all sites.
- Ongoing additional insourcing support until the November 2018 from Medinet to maintain the zero position. Awaiting confirmation for further funding for Q3.
- Development of alternative diagnostic pathway in partnership with Radiology (CT colongraphy)
- Continued focus on effective triage of referrals
- Partnership working with Hywel Dda underway. Currently benchmarking points per list and early discussions are underway to see if clinical cross cover for staffed sessions in ABMU can be facilitated.
- Singleton Endoscopy Unit refurbishment has now been completed and the unit is now environmentally JAG compliant.

What are the main areas of risk?

- Routine activity being displaced by cancer, urgent and RTT patients with significant pressures in Gastroenterology and an increase in USC referrals.
- Ability to maintain the number of additional sessions undertaken with a very small group of Endoscopists.

How do we compare with our peers?

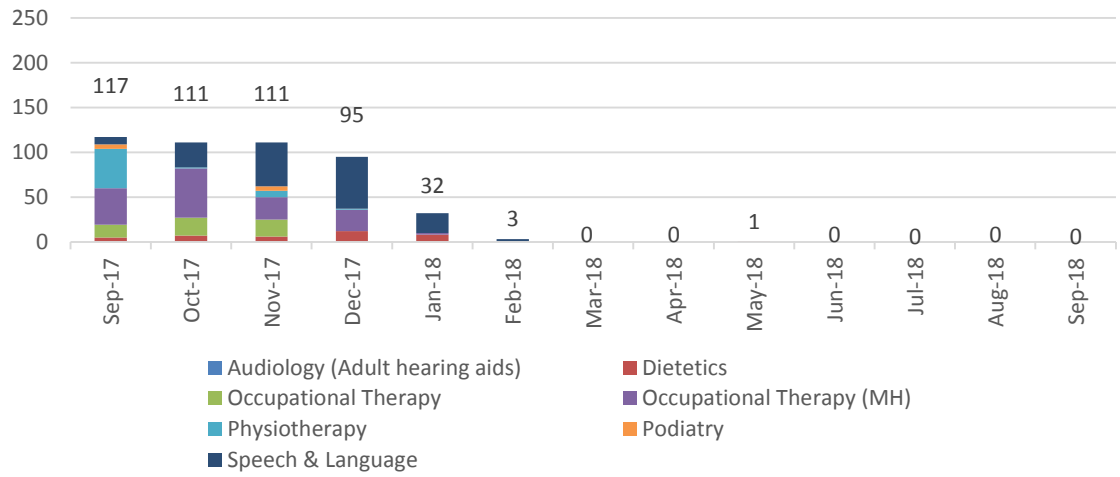
- ABMU endoscopy performance continues to be good in comparison with the rest of Wales, although performance has improved for some previously underperforming Health Boards.

TIMELY CARE - PEOPLE IN WALES HAVE TIMELY ACCESS TO SERVICES BASED ON CLINICAL NEED AND ARE ACTIVELY INVOLVED IN DECISIONS ABOUT THEIR CARE

Measure 1: Number of patients waiting more than 14 weeks for a specified Therapy

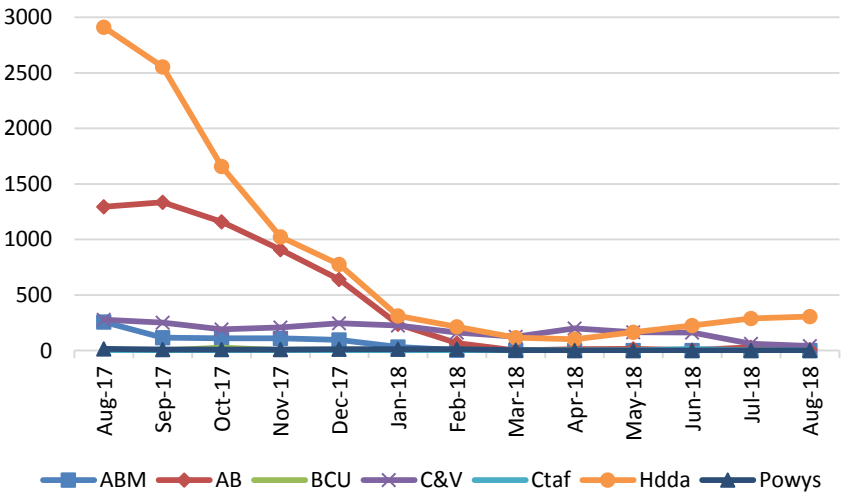
Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			**Executive Lead :** Darren Griffiths Associate Director of Performance	
Outcome Statement : To ensure the best possible outcome, my condition is diagnosed early and treated in accordance with clinical need				
Period : September 2018	**IMTP Profile Target :** (1) 0	**WG Target :** (1) 0	**Current Status :** ✓	**Movement :** ↓ Improving
Current Trend: Sep 17 - Sep 18				

Measure 1: Number of patients waiting more than 14 weeks for a specified Therapy



Benchmarking

Measure 1: Number of patients waiting more than 14 weeks for a specified Therapy



Aug-18	
ABM	0
AB	9
BCU	0
C&V	42
Ctaf	0
Hdda	307
Powys	2

Source : NHS STATS WALES October 2018

Measure 1: Number of patients waiting more than 14 weeks for a specified Therapy

How are we doing?

- Waiting times targets achieved a nil position at the end of March 2018 across all therapy services and are being sustainably met currently. Walk in Clinics are supporting therapies such as Physiotherapy and Podiatry to manage new demand on the day and telephone services are also available to provide advice and offer intervention as required.

What actions are we taking?

- Teams continue to support each other across the Health Board to manage equity in waiting lists
- Proactive waiting list tool implemented which enables services to have an overview to flex staff across the Health Board to address 'hot spots' or an influx of referrals in one area
- In house developments continue, redesigning service models to utilise alternative skill mix wherever possible
- Ensuring booking is completed well in advance to provide sufficient headroom to re-book should patients cancel in month
- Ongoing validation of the waiting lists

What are the main areas of risk?

- Planned maternity leave and inability to backfill with temporary posts
- Increasing demand on Walk in Clinics
- Vacancies and national shortage of qualified therapists

How do we compare with our peers?

- The Health Board is performing as well as or above our peers

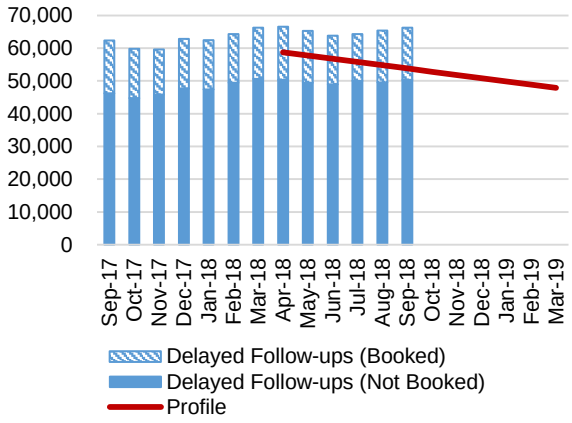
TIMELY CARE - PEOPLE IN WALES HAVE TIMELY ACCESS TO SERVICES BASED ON CLINICAL NEED AND ARE ACTIVELY INVOLVED IN DECISIONS ABOUT THEIR CARE

Measure 1: The number of patients waiting for an outpatient follow-up (booked and not booked) who are delayed past their agreed target date for all specialties
Measure 2: The number of patients waiting for an outpatient follow-up (booked and not booked) who are delayed past their agreed target date for planned care specialties (Ophthalmology, ENT, T&O, Dermatology & Urology)

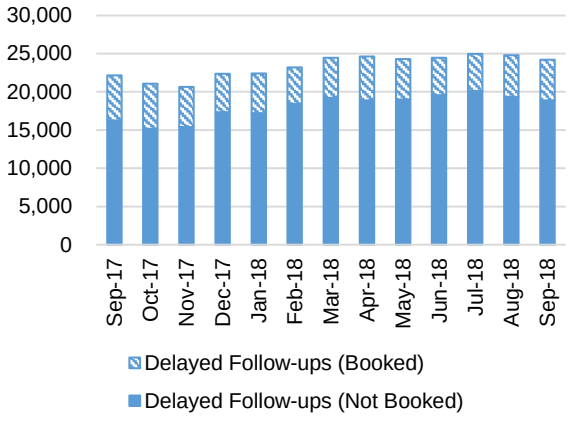
Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			**Executive Lead :** Darren Griffiths Associate Director of Performance	
Outcome Statement : To ensure the best possible outcome, my condition is diagnosed early and treated in accordance with clinical need				
Period : September 2018	**IMTP Profile Target :** (1) 53,801	**WG Target :** 12 month reduction trend	**Current Status :** ✗	**Movement :** ↑ ● Worsening

Current Trend: Sep 17 - Sep 18

(1) Number of patients waiting for an outpatient follow-up (booked and not booked) who are delayed past their agreed target date for all specialties

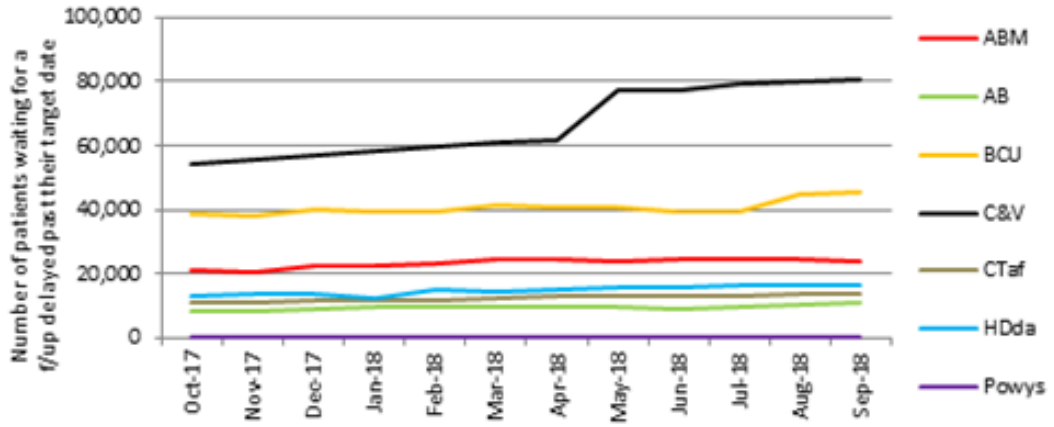


(2) Number of patients waiting for an outpatient follow-up (booked & not booked) who are delayed past their agreed target date for planned care specialties



Benchmarking

(2) Number of patients waiting for an outpatient follow-up (booked and not booked) who are delayed past their agreed target date for planned care specialties



Source : NHS WALES OUTCOMES FRAMEWORK, ALL WALES PERFORMANCE SUMMARY (October 2018)

Measure 1: The number of patients waiting for an outpatient follow-up (booked and not booked) who are delayed past their agreed target date for all specialties
Measure 2: The number of patients waiting for an outpatient follow-up (booked and not booked) who are delayed past their agreed target date for planned care specialties (Ophthalmology, ENT, T&O, Dermatology & Urology)

How are we doing?

- The number of patients waiting for a follow up appointment delayed past their target date (booked and non-booked) has increased from 62,346 (Sept 2017) to 66,269 (Sept 2018).
- Delayed Follow Up (Not Booked): In-month performance has deteriorated with an increase in the number of not booked patients waiting for a follow up appointment delayed past their target date from 49,543 to 50,291. There has been a further increase in delayed follow up not booked when compared with the same period 12 months ago (46,251 to 50,291).
- Delayed Follow Up (Booked): In-month performance has slightly deteriorated with an increase in the number of booked patients waiting for a follow up appointment delayed past their target date from 15,864 to 15,978. There has been small reduction in the number of delayed follow ups booked with the same period 12 months ago (16,095 to 15,978).
- In Sept 2018 the Health Board is 12,469 higher than the IMTP profile.

What actions are we taking?

- Each Delivery Unit has developed a plan to address their Delayed Follow Up Not Booked / Delayed Follow Up Booked position. These plans are overseen by the Outpatient Improvement Group which in turn reports to the Planned Care Supporting Delivery Board. Each Plan has a Managerial lead for each delivery unit and who will regularly monitored through local delivery mechanisms and the Outpatient Improvement Group.
- Updated action plans have been received from the Morriston and Neath Port Talbot Delivery Units – and awaited from the remaining delivery Units for Q3.
- Additional funding is being released to support short term validation reviews of the FunB lists – these are being led by the managerial delivery unit lead.
- An SBAR for medium to long term sustainability solution to this reduction is in final preparations for consideration by the IBG. The Document is being developed by the Project Lead with the support of the delivery unit leads.
- A Status report is being prepared for consideration at the November Finance and Performance Committee – to be presented by Dr Sandra Husbands – Executive Director Lead.
- Internal Audit have completed their review of progress against the WAO recommendations. Their report has been received – an action plan is in preparation to address their recommendations and should be available by the 2nd November. A level of investment has been agreed to address the increasing numbers of potential erroneous entries on the FunB lists and to clean this profile. This will be led by the Outpatient Improvement Group with the support of the delivery Unit management leads through to the end of the financial year.
- The National Outpatient Modernisation Working Group has been refreshed and actively taking forward new measures to address these pressures which are being seen across Wales. Actions include improved coding, clarification of virtual clinic patients, shared learning, and stronger information reporting by specialty.

What are the main areas of risk?

- Wales Audit Office review (2015 and 2017) has highlighted that that there is a need for greater clinician engagement in the recording of clinical risks associated with delayed follow up appointments; there are insufficient mechanisms in place to routinely report these clinical risks to the Board; and that issues persist with the management of the FUNB list.
- Need to better prioritise validation activities. Service Delivery Units to provide regular assurance reports to Health Board Quality & Safety Committee and Outpatient Transformation Work stream.

How do we compare with our peers?

- Most Health Boards have experienced a deteriorating position in the number of patients waiting for an outpatient follow up (booked and not booked) who are delayed past their target date for planned care specialties from Sept 2017 to Sept 2018.

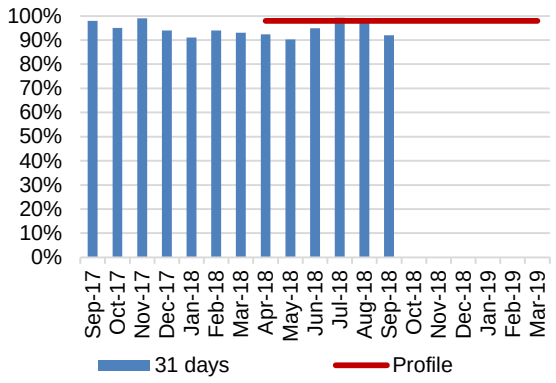
TIMELY CARE - PEOPLE IN WALES HAVE TIMELY ACCESS TO SERVICES BASED ON CLINICAL NEED AND ARE ACTIVELY INVOLVED IN DECISIONS ABOUT THEIR CARE

Measure 1: % of patients newly diagnosed with cancer not via the urgent route that started definitive treatment within 31 days
Measure 2: % of patients newly diagnosed with cancer via the urgent suspected route that started definitive treatment within 62 days

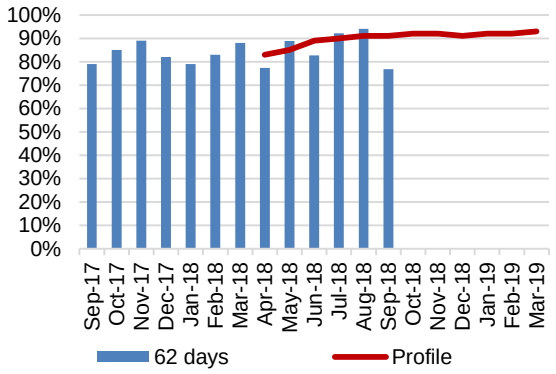
Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			**Executive Lead :** Darren Griffiths Associate Director of Performance	
Outcome Statement : To ensure the best possible outcome, my condition is diagnosed early and treated in accordance with clinical need				
Period: September 2018	**IMTP Profile Target :** (1) 98% (2) 91%	**WG Target :** (1) 98% (2) 95%	**Current Status :** ✗	**Movement :** ↓ ● Worsening

Current Trend: Sep 17 - Sep 18

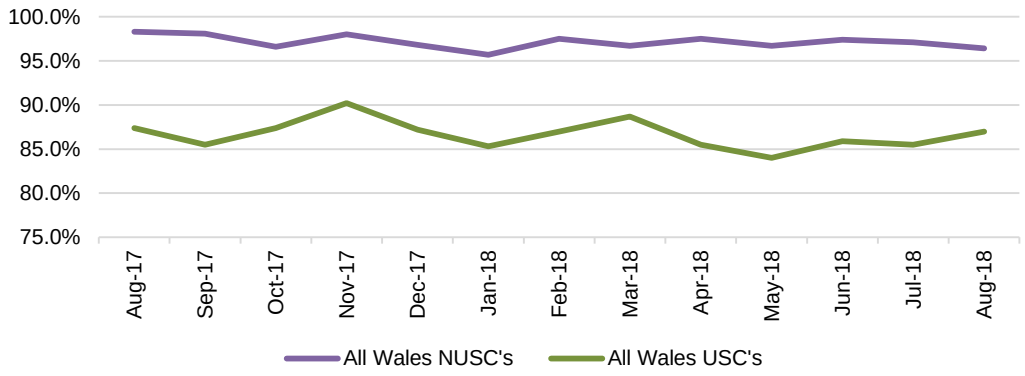
(1) % of patients newly diagnosed with cancer not via the urgent route that started treatment within 31 days



(2) % of patients newly diagnosed with cancer via the urgent suspected route that started treatment within 62 days



Benchmarking



Source : NHS WALES OUTCOMES FRAMEWORK, ALL WALES PERFORMANCE SUMMARY (October 2018)

Measure 1: % of patients newly diagnosed with cancer not via the urgent route that started definitive treatment within 31 days
Measure 2: % of patients newly diagnosed with cancer via the urgent suspected route that started definitive treatment within 62 days

How are we doing?

- NUSC performance for September 2018 is 96% (6 breaches).
- USC performance for September 2018 is 83% (25 breaches).
- USC referrals received by the Health Board remain high. The monthly average during the 13 months August 17 to August 18 is 1837. 2031 referrals were received in August 2018.
- Patients waiting over 62 days in backlog has been on an upwards trend throughout the summer and to the end of September, with 61 patients reported in the 30th September PTL. This increase in backlog demonstrates lost capacity over the summer period which will have a negative impact on the breach position for a number of months.

What actions are we taking?

- Full implementation of the PMB pathway with aim to improve waiting times for diagnostics, which will reduce overall wait from referral to treatment. The new clinic model will be implemented from the 5th November 2018.
- All theatre lists reviewed. Additional weekend WLI theatres arranged to accommodate USC and NUSC patients (it varies, but Gynaecology for six weekends).
- Additional endoscopy lists undertaken to keep waits to a minimum
- Advert for Consultant posts in Breast Radiology, Gynae-Oncology Surgery and Oncology have been placed.
- Additional resource of a Consultant Radiographer who has moved to the area for two days a week in support of the Breast Service, to work 1 day from Singleton and 1 day from Neath which will improve sustainability of the diagnostic clinics and reduce lengthy first assessment waits.
- Building on the current portfolio of Demand and Capacity work, further analysis has been undertaken in support of Endoscopy; Gynaecology and Radiology; and is being used by the Services in development of business plans.
- Review of the practice around authorisation of Annual Leave of medical staff. Medical Director has asked that the Consultant Groups agree staffing levels to ensure sufficient demand is available during peak holiday periods.
- Additional resource in cancer tracking posts at POWH has been agreed and is being recruited.

What are the main areas of risk?

- Unscheduled Care pressures through winter on bed capacity, although site management processes aim to minimise impact on cancer cases.
- Continued growth in demand and therefore the backlog
- Challenges to appoint to vacant posts and time lag in developing new workforce models
- Delays to diagnostic endoscopy service
- Growing waiting times in Chemotherapy and radiotherapy –pressures around vacancies / planned maternity leave / changes in NICE guidance.
- Ongoing issues with delivery of Urological services at Princess of Wales Hospital
- Ongoing issues with delivery of Breast services.
- Delays due to lack of Gynaecological surgical capacity
- Lack of tracking capacity until new staff are in post at POWH and through sickness elsewhere

How do we compare with our peers?

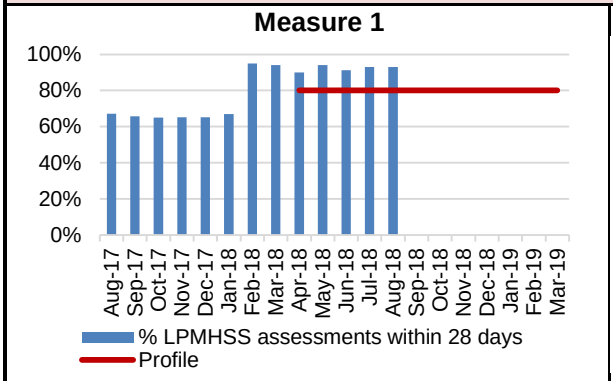
- Since April 2018 the Health Board's USC performance has improved with July and August performance the best in Wales; however this is not sustainable, with previously mentioned lost capacity over the Summer the performance will deteriorate and likely to struggle in comparison with other Health Boards at the end of Quarter 2 and during Quarter 3.

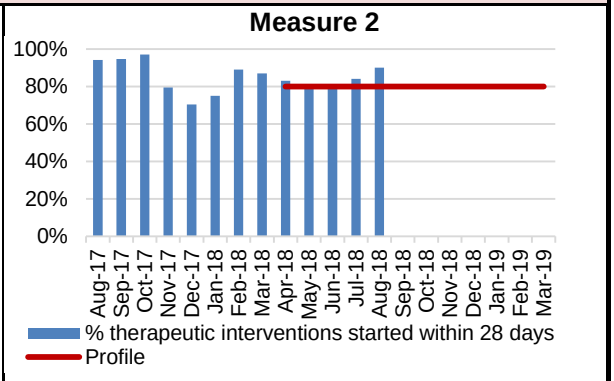
TIMELY CARE - PEOPLE IN WALES HAVE TIMELY ACCESS TO SERVICES BASED ON CLINICAL NEED AND ARE ACTIVELY INVOLVED IN DECISIONS ABOUT THEIR CARE

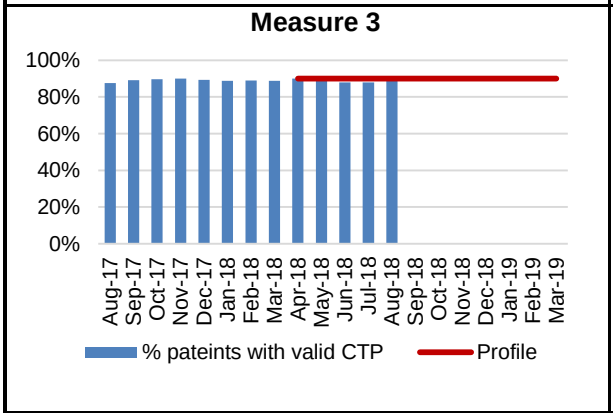
Measure 1: % of assessment by the Local Primary Mental Health Support Service (LPMHSS) undertaken within 28 days from receipt of referral
Measure 2: % of therapeutic interventions started within 28 days following assessment by LPMHSS
Measure 3: % of Health Board residents in receipt of secondary Mental Health services (all ages) to have a valid Care and Treatment Plan (CTP)
Measure 4: % of qualifying patients (compulsory & informal/voluntary) who had their first contact with an Independent Mental Health Advocacy (IMHA) within 5 working days of their request for an IMHA

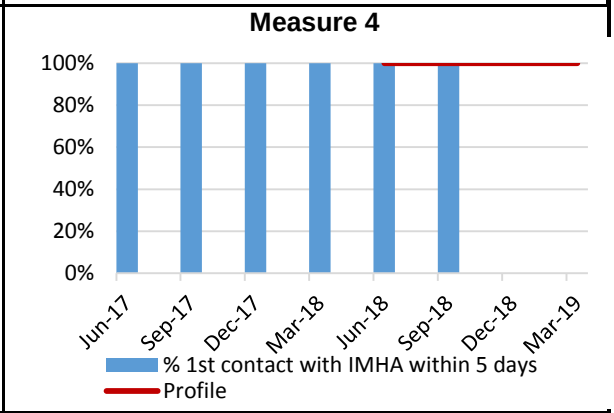
Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access				**Executive Lead :** Darren Griffiths Associate Director of Performance
Outcome Statement : To ensure the best possible outcome, my condition is diagnosed early and treated in accordance with clinical need				
Period : August 2018	**IMTP Profile Target :** (1)80% (2)80% (3)90% (4)100%	**WG Target :** (1)80% (2)80% (3)90% (4)100%	**Current Status :** ✓	**Movement :** ↑ Improving

Current Trend: Aug 17 - Aug 18

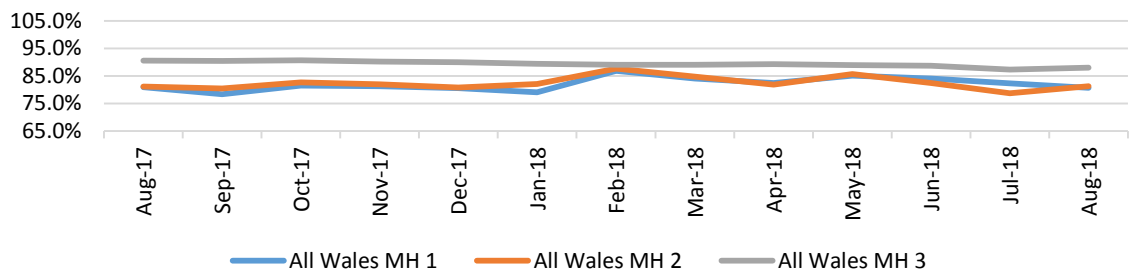








Benchmarking



Source : NHS WALES OUTCOMES FRAMEWORK, ALL WALES PERFORMANCE SUMMARY (October 2018)

Measure 1: % of assessment by the Local Primary Mental Health Support Service (LPMHSS) undertaken within 28 days from receipt of referral
Measure 2: % of therapeutic interventions started within 28 days following an assessment by LPMHSS
Measure 3: % of Health Board residents in receipt of secondary Mental Health services (all ages) to have a valid Care and Treatment Plan (CTP)
Measure 4: % of qualifying patients (compulsory & informal/voluntary) who had their first contact with an Independent Mental Health Advocacy (IMHA) within 5 working days of their request for an IMHA

How are we doing?

- Mental Health 1 - ABMU met the target for 7 of the 13 months shown. This data excludes CAMHS which is collated by Cwm Taf Health Board. It should be noted that actual waiting time is irrespective of weekends and bank holidays.

- Mental Health 2 - intervention levels met the target for 10 of the 13 months shown. This data excludes CAMHS from the analysis, which is collated by Cwm Taf HB. Meeting the target does not tell you how many people are waiting or the length of longest waits, but we manage and monitor the lists locally.

- Mental Health 3 - This data covers Adult, Older People, CAMHS and Learning Disability Services. ABMU met the target from 5 of the 12 months shown. There was a slight dip in June and July but at the end of August ABMU were 90% compliant

What actions are we taking?

- The LMPHSS has benefited from recent additional Welsh Government resources to help build up the local teams. This will allow the service to help keep pace with additional demand.
- The LPMHSS is in the process of developing a further range of group interventions, in order to offset the demand for therapy.

What are the main areas of risk?

- For assessment and interventions targets, risks relate to potentially increasing demand and the availability of suitably experienced staff.
- One of the actions of the Community Mental Health Team (CMHT) assurance group is to consider the level of demand for secondary mental health services and capacity of care coordinators. Protocols to inform safe and effective discharge from secondary care are being developed to mitigate against the risks of overcapacity.

How do we compare with our peers?

August 2018

- All-Wales MH1 measure ranged from 71% to 93% 81% ABMU
- All-Wales MH2 measure ranged from 60% to 91% 90% ABMU
- All-Wales MH3 measure ranged from 81% to 93% 90% ABMU

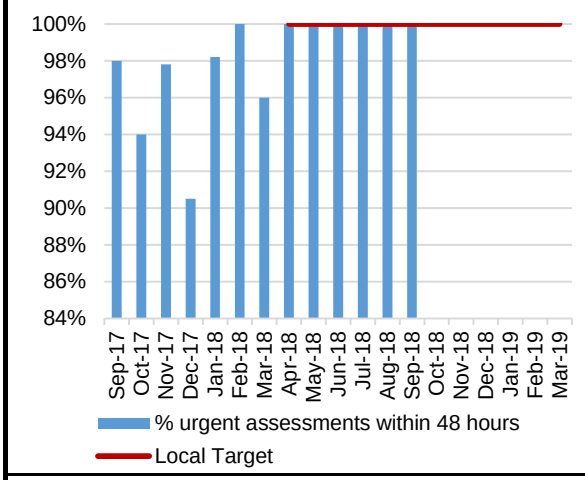
TIMELY CARE - PEOPLE IN WALES HAVE TIMELY ACCESS TO SERVICES BASED ON CLINICAL NEED AND ARE ACTIVELY INVOLVED IN DECISIONS ABOUT THEIR CARE

(1) Crisis - % Urgent Assessment by CAMHS undertaken within 48 Hours from receipt of referral
(2) NDD - % Patients with Neurodevelopmental Disorders receiving a Diagnostic Assessment within 26 weeks
(3) P-CAHMS - % Routine Assessment by CAMHS undertaken within 28 days from receipt of referral
(4) P-CAHMS - % Therapeutic interventions started within 28 days following assessment by LPMHSS
(5) S-CAHMS - % Health Board residents in receipt of CAMHS to have a valid Care and Treatment Plan (CTP)
(6) S-CAHMS - % Routine Assessment by SCAMHS undertaken within 28 days from receipt of referral

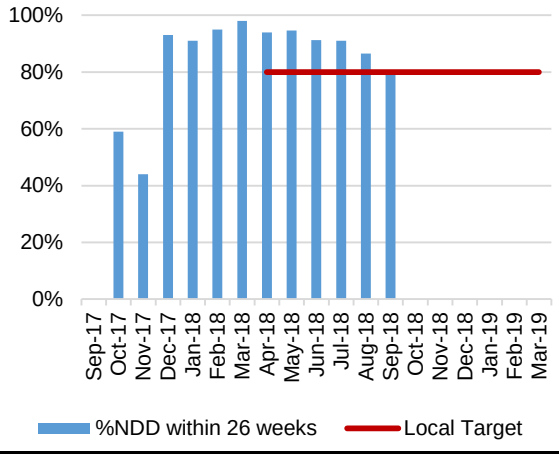
Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			**Executive Lead :** Siân Harrop-Griffiths Director of Strategy	
Period : September 2018	**IMTP Profile Target :** N/A	**Local Target :** (1) 100% (5) 90% (2,3,4,6) 80%	**Current Status :** ✗	**Movement :** ↑ ● Improving

Current Trend: Sep 17 - Sep 18

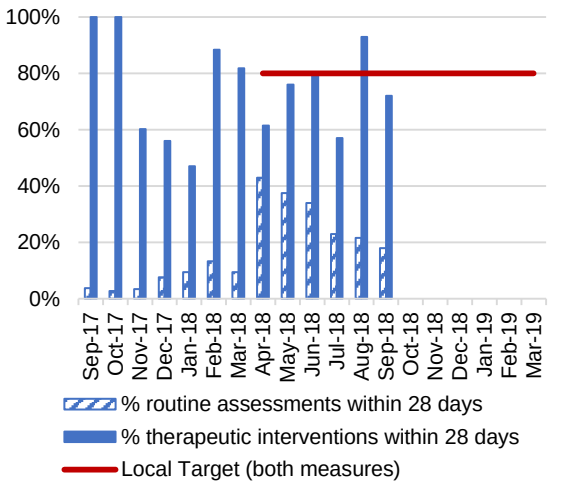
Crisis



NDD

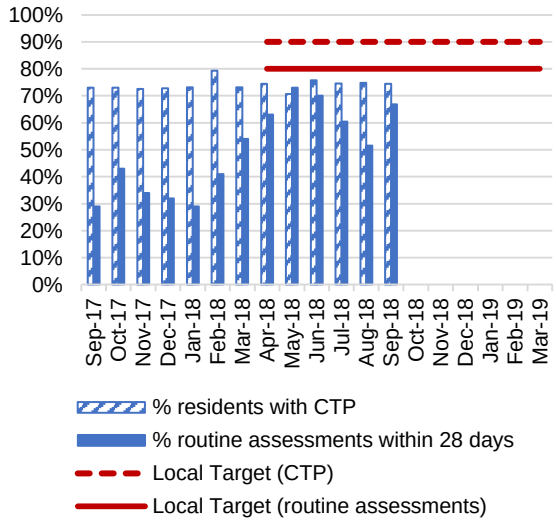


P-CAMHS



Note: Includes patients under 18 but who are seen by ABMU as they are over 17yrs and 9 months.

S-CAMHS



Source : Cwm Taf LHB

(1) Crisis - % Urgent Assessment by CAMHS undertaken within 48 Hours from receipt of referral
(2) NDD - % Patients with Neurodevelopmental Disorders receiving a Diagnostic Assessment within 26 weeks
(3) P-CAHMS - % Routine Assessment by CAMHS undertaken within 28 days from receipt of referral
(4) P-CAHMS - % Therapeutic interventions started within 28 days following assessment by LPMHSS
(5) S-CAHMS - % Health Board residents in receipt of CAMHS to have a valid Care and Treatment Plan (CTP)
(6) S-CAHMS - % Routine Assessment by SCAMHS undertaken within 28 days from receipt of referral

How are we doing?

- Measure 1: Crisis - The Crisis Service is now operating 7 days a week, and the team have the capacity to consistently achieve the target of 100%. Compliance against the target has been 100% since April '18.
- Measure 2: NDD - Compliance against this measure has deteriorated to 80% in September. The target has been achieved to date; however, it is unlikely that the Service will maintain this due to an increase in referrals. The increase has been experienced across Wales, due to increased awareness of the service available.
- Measure 3: P-CAMHS - overall access to P-CAMHS has improved significantly over the last 6 months, with the number of patients waiting reduced. However, the compliance against the Welsh Government target has deteriorated again this month due to a number of vacancies and failure to recruit.
- Measure 4: P-CAMHS - compliance against the 80% target has varied over the last 12 months, and the August data shows that compliance did reach over 80%. However, it is a fragile service with a small workforce, and a number of vacancies with limited clinical time is the reason for a decline in performance in September.
- Measure 5: S-CAMHS – The performance trend for this target has been consistent over the last 12 months, and 80% has only been achieved once in February. Vacancies and a lack of clinical time is again behind the non-achievement of this target.
- Measure 6: S-CAMHS - Compliance had steadily improved since January 2018 however, a deterioration was seen in July and August, as a result the number of vacancies. The September position has improved, and Cwm Taf are still working towards achieving this target by the end of November.

What actions are we taking?

- NDD – Waiting list sessions have been undertaken utilising vacancy slippage monies, however as vacancies are filled this will run out. Once the NDD team are at full complement a demand & capacity exercise will be undertaken, however there is likely to be a significant gap due to the increase in referrals.
- CAMHS –The deterioration in performance is down to a number of vacancies across the Service, with a number of staff on maternity leave, and vacancies having to be re-advertised. ABMU has agreed to the utilisation of the vacancy underspend to fund waiting list initiatives to improve the position. The aim is to achieve the 80% target by the end of November. Cwm Taf have also submitted a proposal to the Welsh Government to secure additional funds for WLIs to deliver the targets. The results of the Demand & Capacity exercise have been shared with ABMU. It was agreed that the Health Board and the Service should explore any potential efficiencies as a result of the proposed service re-design in the first instance including the single point of access.

What are the main areas of risk?

- The inability to recruit and retain staff is a recurring theme, and the relatively small size of these specialist teams is a concern that ABMU will continue to discuss with Cwm Taf via formal commissioning meetings. Particular issues are evident in Primary CAMHS provision where about half of the substantive staff have obtained other jobs and the opportunity is therefore being taken to discuss with Cwm Taf and the Mental Health / Learning Disability Delivery Unit alternative options for the delivery of this service.

How do we compare with our peers?

- Unable to compare performance for ABMU residents with Cardiff & Vale and Cwm Taf residents as performance information not available for comparison. ABMU working jointly with Cardiff & Vale and Cwm Taf Health Boards to look at benchmarking data.

9.6 Individual Care

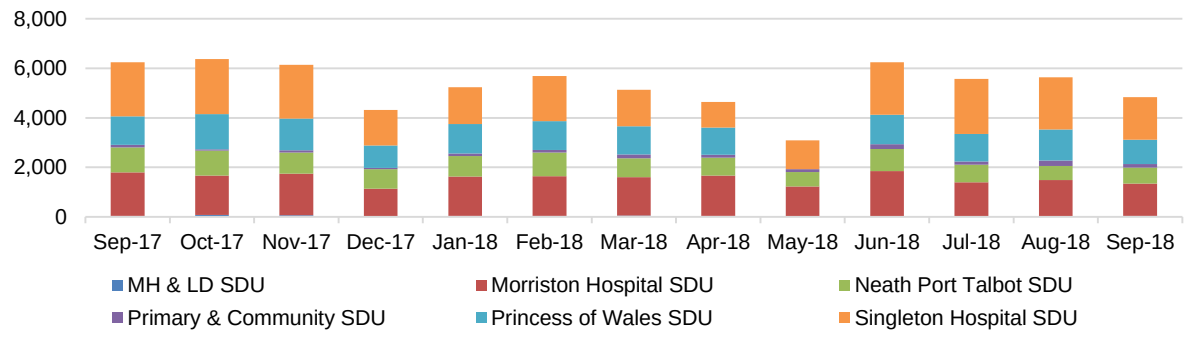
INDIVIDUAL CARE – PEOPLE IN WALES ARE TREATED AS INDIVIDUALS WITH THEIR OWN NEEDS AND RESPONSIBILITIES

Measure 1: Number of friends and family surveys completed
Measure 2: % of who would recommend and highly recommend
Measure 3: % of all Wales surveys scoring 9 or 10 on overall satisfaction

Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			**Executive Lead :** Gareth Howells Director of Nursing & Patient Experience	
Period : September 18	**IMTP Profile Target :**	**Local Target :** (1) Increase, (2) 90%, (3) 90%	**Current Status :** ✕	**Movement :** ↑ ● Improving

Current Trend: Sep 17 – Sep 18

(1) Number of friends and family surveys completed



(2) % of who would recommend and highly recommend

	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18
MH & LD SDU	76%	87%	84%	65%	73%	91%	76%	72%	52%	79%	31%	65%	90%
Morriston Hospital SDU	94%	94%	94%	92%	93%	94%	93%	94%	94%	94%	94%	92%	93%
Neath Port Talbot SDU	97%	98%	99%	99%	98%	98%	99%	99%	98%	99%	99%	98%	98%
Primary & Community SDU	93%	85%	93%	90%	90%	91%	90%	89%	93%	94%	93%	93%	94%
Princess of Wales SDU	96%	95%	95%	94%	95%	94%	94%	95%	95%	96%	96%	95%	95%
Singleton Hospital SDU	96%	95%	97%	96%	96%	96%	95%	94%	94%	97%	96%	97%	97%
HB Total	**96%**	**95%**	**96%**	**95%**	**95%**	**95%**	**95%**	**95%**	**95%**	**96%**	**96%**	**95%**	**96%**

(3) % of All Wales surveys scoring 9 or 10 on overall satisfaction

	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18
MH & LD SDU	NS	87%	50%	100%	NS	NS	0%	-	-				
Morriston Hospital SDU	96%	80%	91%	94%	77%	87%	91%	93%	96%	74%	87%	83%	92%
Neath Port Talbot SDU	88%	86%	83%	76%	91%	88%	80%	62%	80%	80%	93%	87%	100%
Primary & Community SDU	100%	86%	94%		95%	100%	93%	92%	97%			91%	87%
Princess of Wales SDU	78%	80%	80%	77%	79%	69%	79%	87%	82%	86%	77%	63%	87%
Singleton Hospital SDU	82%	84%	81%	85%	79%	84%	79%	85%	86%	90%	84%	95%	79%
HB Total	**88%**	**83%**	**84%**	**84%**	**83%**	**87%**	**84%**	**87%**	**89%**	**84%**	**85%**	**87%**	**89%**

NS= No Surveys Target = 90%

Benchmarking

	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18
ABMU Response %	27.5%	28.9%	27.0%	28.9%	20.0%	22.1%	25.0%	23.3%	19.4%	16.9%	30.1%	26.1%	26.8%
ABMU Recommendation %	95.0%	95.4%	95.5%	96.0%	95.0%	95.7%	95.5%	95.7%	95.1%	95.4%	97.2%	96.5%	96.2%
Top Equivalent Organisation Response %	18.8%	15.7%	17.5%	17.0%	14.1%	14.6%	21.3%	27.7%	17.6%	27.3%	27.0%	19.3%	19.8%
Top Equivalent Organisation Recommendation %	96.8%	97.7%	97.0%	98.1%	97.0%	97.5%	95.0%	93.7%	97.4%	94.2%	92.0%	94.1%	97.1%
NHS England Benchmark Response %	25.8%	24.6%	24.9%	25.1%	21.4%	22.7%	23.9%	22.6%	24.4%	25.1%	24.8%	24.8%	24.6%
NHS England Benchmark Recommendation %	95.6%	95.6%	95.6%	95.6%	95.0%	95.5%	95.5%	95.3%	95.6%	95.8%	95.7%	95.6%	95.5%

Source : ABMU Datix System

Measure 1: Number of friends and family surveys completed
Measure 2: % of who would recommend and highly recommend
Measure 3: % of all Wales surveys scoring 9 or 10 on overall satisfaction

How are we doing?

- Health Board Friends & Family patient satisfaction level in September 2018 was 96% which is the fifth time in a year we have reached this high percentage score.
- Neath Port Talbot Hospital completed 644 surveys for September, with a recommended score of 98%.
- Singleton Hospital completed 1,722 surveys for September, with a recommended score of 97%.
- Morriston Hospital completed 1,310 surveys for September, with a recommended score of 94%.
- Princess of Wales Hospital completed 983 surveys for September, with a recommended score of 95%.
- Mental Health & Learning Disabilities completed 29 surveys for September, with a recommended score of 90%
- Primary & Community Care completed 145 surveys for September, with a recommended score of 94%

What actions are we taking?

- Second Workshop with the PALS and PEAS teams: September 17th. Staff attending the workshop drafted a PALS Policy, agreed standardised uniform and name. Issues raised regarding additional training for the Datix system and coding. Third workshop to take place during December to strengthen Datix knowledge and coding of complaints.

What are the main areas of risk?

- New Welsh Government Validated Patient Survey questions sent to all Chief Executives across Wales. Changes to the survey questions required. Snap System update with the new questions will need to take place during March 2019, to coincide with the financial year and annual archiving of the Snap system.

How do we compare with our peers?

- Monthly/bi monthly data not available on an all-Wales basis to compare.

9.7 Our Staff & Resources

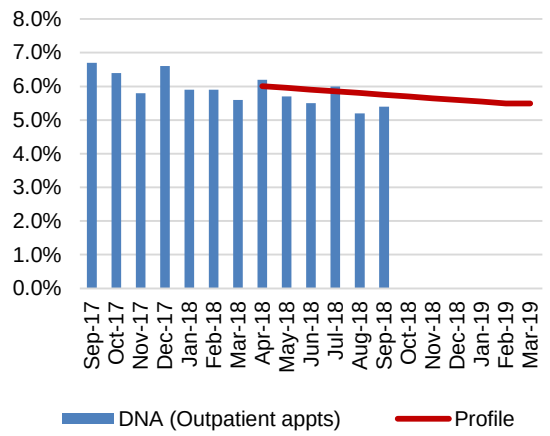
OUR STAFF AND RESOURCES: PEOPLE IN WALES CAN FIND INFORMATION ABOUT HOW THEIR NHS IS RESOURCED AND MAKE CAREFUL USE OF THEM

Measure 1: % New Outpatient that Did Not Attend (DNA) For Specific Specialties
Measure 2: % Follow Up Outpatient that Did Not Attend (DNA) For Specific Specialties
Specific Specialties: *includes General Surgery, Urology, T&O, ENT, Ophthalmology, Oral Surgery, Neurosurgery, Combined Medicine, Dermatology, Rheumatology, Paediatrics and Gynaecology*

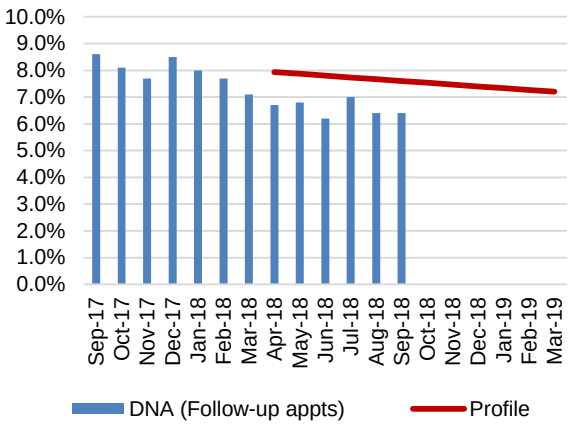
Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			**Executive Lead :** Darren Griffiths Associate Director of Performance	
Outcome Statement : I work with the NHS to improve the use of resources				
Period : September 2018	**IMTP Profile Target :** (1) 5.75% (2) 7.6%	**WG Target :** 12 month reduction trend	**Current Status:** ✓	**Movement :** ↓ Improving

Current Trend: Sep 17 - Sep 18

(1) % New Outpatient that Did Not Attend

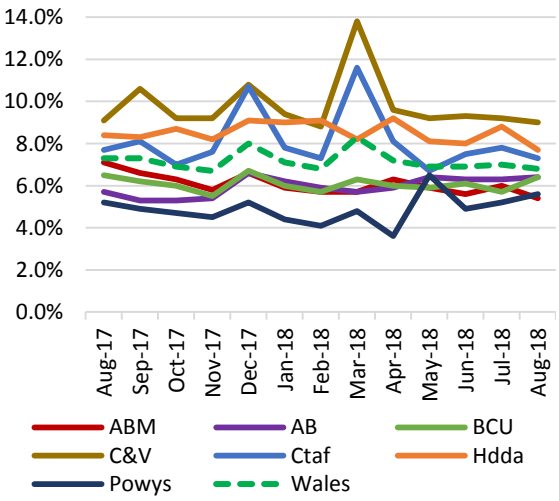


(2)% Follow Up Outpatient that Did Not Attend

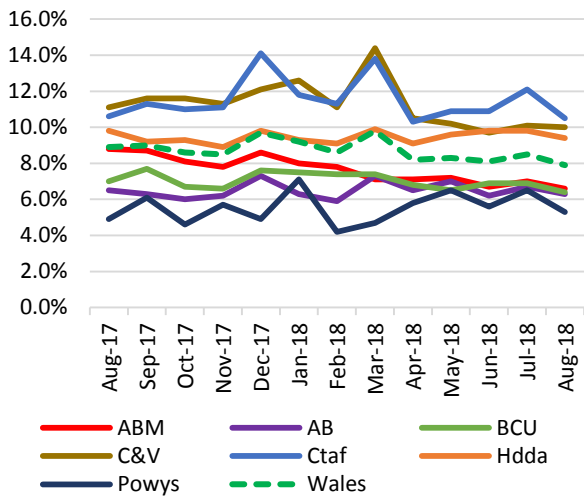


Benchmarking

(1) % New Outpatient that Did Not Attend



(2) % Follow Up Outpatient that Di d Not Attend



Source : NHS WALES OUTCOMES FRAMEWORK, ALL WALES PERFORMANCE SUMMARY (October 2018)

Measure 1: % New Outpatient that Did Not Attend (DNA) For Specific Specialties
Measure 2: % Follow Up Outpatient that Did Not Attend (DNA) For Specific Specialties

How are we doing?

- New Outpatient DNA: From September 2017 - September 2018 performance has improved from 6.7% to 5.4%.

- Follow-Up DNA: From September 2017 - Sept 2018 performance has improved from 8.6% to 6.4%.

What actions are we taking?

- Outpatient appointment text reminder service implementation - review of current arrangements underway by Information / Service Improvement team – recommendation by the end of Q3.
- Project lead to work with GP clusters and patients to inform the development of alternative methods of service delivery to support patients in the most appropriate setting including nurse led / advanced practitioner led clinics.
- Each Delivery Unit has developed a plan to address their DNA position. These plans, overseen by the Outpatient Improvement Group and led by nominated managerial leads from each delivery unit, have set out objectives to achieve the Annual Plan 2018/19 target of a reduction in the DNA rate of 10%.

Actions to be undertaken by each delivery unit lead in Q3 include:

- To review patient data extract and determine compliance with Health Board DNA policy.
- Clinicians to contact patients who DNA to determine reasons for non-attendance and to inform actions that the Health Board can take to address
- Continue to explore increased opportunities for partial booking.
- Adhering to best practice guidelines

What are the main areas of risk?

- The Wales Audit Office identified in a review of ABMU Outpatients in 2015 the need to ensure patients receive appointment letters in a timely manner in order to reduce DNAs. The Outpatient Transformation work stream is continuing to explore electronic appointment management options to help address this issue.
- It is important for the Health Board to gain a better understanding of the specialties and clinical conditions which present the most risks of harm to patients who DNA their appointment.
- RTT risk to the Health Board as a result of underutilised capacity for new and follow up appointments with associated financial implications for idle capacity, rearranging appointments and potentially needing to arrange additional waiting list clinics.

How do we compare with our peers?

- At Sept 2018, ABMU performance continues to be better than the all-Wales average on New and Follow Up DNA performance.
- New DNA: ABM, BCU, CT, and HD have experienced an improved performance from August 2017; AB, C&V and Powys position has deteriorated.
- Follow Up DNA: ABM, AB, BCU, C&V, CT and HD experienced an improved performance from August 2017; Powys' position has deteriorated.

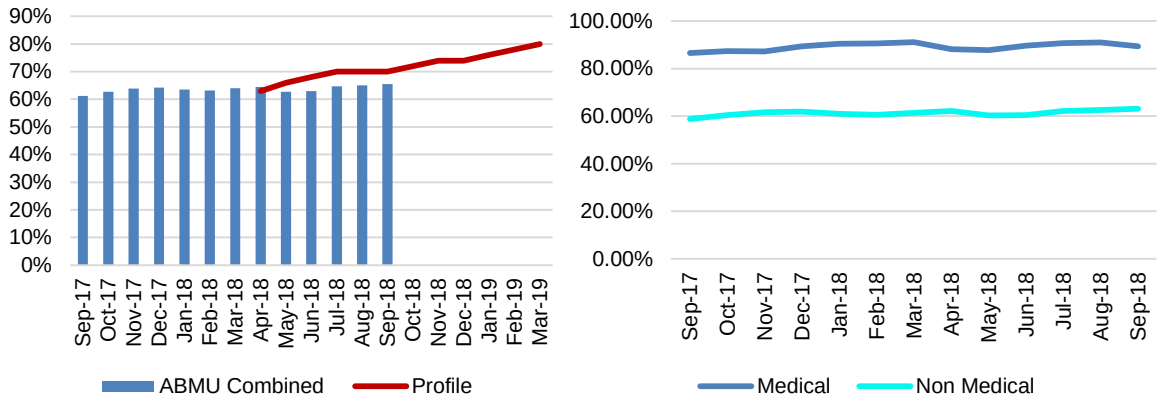
OUR STAFF AND RESOURCES: PEOPLE IN WALES CAN FIND INFORMATION ABOUT HOW THEIR NHS IS RESOURCED AND MAKE CAREFUL USE OF THEM

Measure 1: % staff (medical & non-medical) undertaking performance appraisals

Corporate Objective : Securing a Fully Engaged and Skilled Workforce			**Executive Lead :** Hazel Robinson Director of Workforce & OD	
Outcome Statement : Quality trained staff who are fully engaged in delivering excellent care and support to me and my family				
Period : September 2018	**IMTP Profile Target :** 70%	**WG Target :** 85%	**Current Status:** ✗	**Movement :** ↑ ● Improving

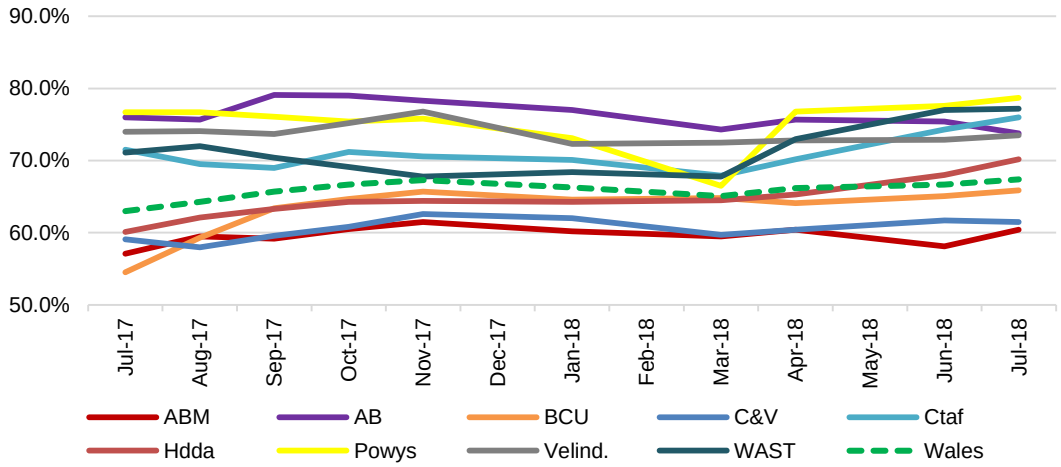
Current Trend: Sep 17 - Sep 18

(1) % staff undertaking performance appraisals



Benchmarking

(1) % staff undertaking performance appraisals



Source : Non Medical: Electronic Staff Record (ESR), Medical : Medical Appraisal and Revalidation System (MARS)/ NHS WALES DELIVERY FRAMEWORK, ALL WALES PERFORMANCE SUMMARY (October 2018)

Measure 1: % staff (medical & non-medical) undertaking performance appraisals

How are we doing?

Medical:

- Excluding any exemptions (new starters, absences e.g. long term sickness, maternity leave etc.) the appraisal rate for the rolling period to September 2018 is 89.5%.
- Appraisals undertaken for period April-September 2018 are at 42.7% and continue to improve.
- The dip in April 2018 reflects a change in the 'denominator', the number of doctors employed /contracted and 'connected' to the Health Board increased from 1335 to 1369. This varies throughout the year but for consistency, the statistics are based on numbers at the beginning of April each year.

Non-Medical:

- Reporting figures demonstrate an increase in PADR compliance- March 2018 61.46% to September 2018 63.17%, This has been an increase in compliance from March to September 2018 by 1.71%
- From the 6 Service Delivery Units (SDUs): Mental Health & Learning Disabilities (MHLD) 76.88% a decrease of 2.14% on the last results, Morriston Delivery Unit (MSDU) 63.59% an increase of 3.96%, Neath Port Talbot (NPT) 70.07% an increase of 2.3%, Primary & Community Care (PCC) 76.12% a decrease of 2.73%, Princess of Wales (POW) 63.28% an increase of 5.16%, Singleton Delivery Unit (SSDU) 63.79% an increase of 4.56% on the last results.

What actions are we taking?

Medical:

- Maintain current performance levels through continuing engagement with Unit Medical Directors, GP Appraisal Co-ordinators and Medical Appraisal Leads - undertaking quarterly exception management process, providing doctors with training and advice.
- Further and ongoing enhancements to MARS (Medical Appraisal and Revalidation System) continue to improve functionality in line with identified changes/developments.
- Unit based Appraisal Leads have now been identified for all Units - they will drive appraisal quality forward and maximise delivery of appraisal benefits, providing support for appraisers.

Non-Medical:

- There is a continuation of focus on training Managers to complete Values Based PADR/use ESR to improve reporting figures on a request basis with bespoke sessions for teams/units when requested. 144 managers have been trained since April 2018.

What are the main areas of risk?

Medical:

- If doctors fall behind on appraisal timescales for revalidation: stress for doctor; diversion of doctor's and management time/resource; potential delayed revalidation; ultimately, consequences for licence to practise if fail to engage.
- Poor quality appraisals - lack of personal/service development and progression; continuation of sub-optimal practices; resistance to change.
- Ensuring new starters and ad hoc doctors are engaged with the annual appraisal process, and relevant information received from previous RO (Responsible Officer).
- Whole Practice Appraisal (WPA) – ensuring doctors declare work undertaken outside of their NHS role within their annual appraisals for revalidation. Revalidation recommendations to the GMC are based on WPA.

Non-Medical:

- Misunderstanding around timings of PADR aligning with increment date.
- Dependence on roll out of Supervisor self-service for PADR Reporting data accuracy, double reporting, use of ESR, accuracy of ESR, IT skills of staff.
- Time to complete PADR's - risk around the quality of PADR versus the target figures.
- Local administrators and locally held data – change of culture and the time scales to do this. NHS pay scales/ increment linked to PADR
- Individual perspectives of the validity and necessity of having a PADR in line with the requirements of the job role i.e. what's the point?

How do we compare with our peers?

- **Medical:** Stats from the RSU (Revalidation Support Unit) show appraisals undertaken from 1st April 2017 - 31st March 2018 in ABMU as 79% of the baseline total number of doctors (based on appraisals completed) this is in line with other Health Boards within Wales.
- **Non-Medical:** There have been slight variations in performance of ABMU in line with other Health Boards across Wales, especially around June 2018 where ABMU's figures start to decline, whereas other Health Board either increase or remain the same. We will look to scope actions taken by other Health Boards in relation to their increase in PADR's compliance.

OUR STAFF AND RESOURCES: PEOPLE IN WALES CAN FIND INFORMATION ABOUT HOW THEIR NHS IS RESOURCED AND MAKE CAREFUL USE OF THEM

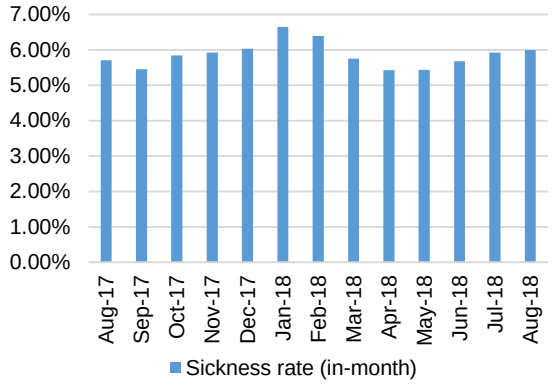
Measure 1: % workforce sickness absence (Rolling 12 months)
Measure 2: % workforce sickness absence (In-month)

Corporate Objective : Securing a Fully Engaged and Skilled Workforce			**Executive Lead :** Hazel Robinson Director of Workforce & OD	
Outcome Statement: Quality trained staff who are fully engaged in delivering excellent care and support to me and family			**(1)Current Status :** ✗	**(1) Movement :** ↑ ● Worsening
Period : August 2018	**IMTP Profile Target :** (1) 5.44%	**WG Target:** 12 month reduction trend	**(2)Current Status :** ✓	**(2) Movement :** ↓ ● Improving

Current Trend: Aug 17 – Aug 18

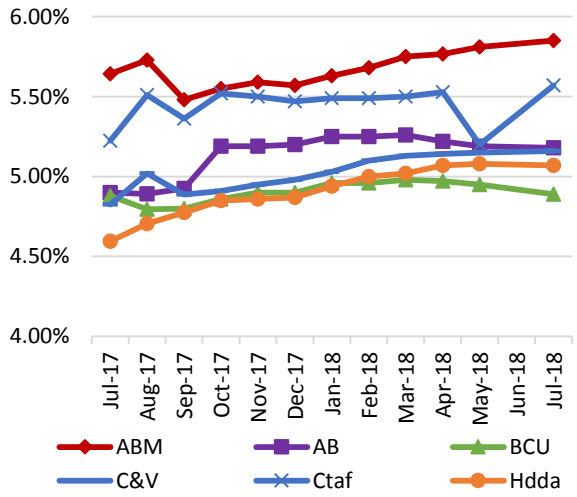
(1) % workforce sickness absence (Rolling 12 months)

(2) % workforce sickness absence (In-Month)



Benchmarking

Sickness Absence Rates



(1) % workforce sickness absence (Rolling 12 months)

LHB	Current	Same Period Comparison		
	Jul-18	Jul-17	Jul-16	Jul-15
Wales	5.27%	⇩ 5.11%	⇩ 5.17%	⇧ 5.48%
ABM	5.85%	⇩ 5.52%	⇩ 5.63%	⇩ 5.48%
AB	5.18%	⇧ 5.28%	⇧ 5.20%	⇧ 5.61%
BCU	4.89%	⇩ 4.86%	⇩ 4.83%	⇧ 5.09%
C&V	5.16%	⇩ 4.86%	⇩ 4.93%	⇧ 5.62%
CTaf	5.57%	⇧ 5.58%	⇩ 5.52%	⇧ 5.94%
HDda	5.07%	⇩ 4.86%	⇧ 5.40%	⇧ 5.65%
Powys	4.69%	⇧ 4.71%	⇩ 4.27%	⇩ 4.18%
PHW	4.08%	⇩ 3.87%	⇩ 3.75%	⇩ 3.71%
Velind.	4.11%	⇩ 3.69%	⇩ 3.74%	⇩ 4.07%
WAST	7.34%	⇩ 6.78%	⇩ 7.02%	⇧ 7.74%

Source : NHS WALES OUTCOMES FRAMEWORK, ALL WALES PERFORMANCE SUMMARY (October 2018)

Measure 1: % workforce sickness absence (Rolling 12 months)
Measure 2: % workforce sickness absence (In-month)

How are we doing?

Rolling 12 month performance:

- Sept 16 - Aug 17 = 5.54%
- Aug 17 - Jul 18 = 5.85%
- Sept 17 - Aug 18 = 5.86%

In Month performance:

- Jul 18 = 5.90%
- Aug 18 = 5.98% (was 5.76% in Aug 17)

- Three of the six units saw their in month performance worsen in August 18 compared to the previous month with Neath Port Talbot seeing a significant increase of more than 1%. Only Mental Health and Learning Disabilities and Primary & Community Care saw an improvement in their cumulative 12 month performance whilst Singleton unit has increased to over 6% and is now the worst performing unit.
- Short term sickness remains under 1.5% and has been for the last 5 months and is the same as last August's level.
- Long term sickness rates continue to be a challenge increasing 0.01% in month and 0.21% more than last August.
- Our highest reason for absence continues to be stress related absence, which increased by 1% compared to last month with 17 more occurrences of sick absence due to stress compared to the previous month.

What actions are we taking?

- Share outputs of best practise case study conducted in three areas of good sickness performance and develop plan for implementation of learnings across all Delivery Units.
- Roll out of long term sickness pathways for MSK conditions to help guide managers in managing common absence conditions.
- Develop an implementation plan for the revised all Wales Managing Attendance policy
- Develop improvement plan for occupational health services based on data analysis and engagement with clinical team.
- Complete roll out of training for this year's Flu Champions
- Continue delivery of Mental Health awareness sessions to managers.
- Continue further delivery of Work related stress risk assessment training for managers.

What are the main areas of risk?

- Failure to maintain continued focus on sickness absence performance may lead to levels increasing.
- Singular focus on sickness management without measured attention on supporting staff attendance through health and wellbeing interventions congruent with our organisational values.
- Direct effect on costs in terms of bank, agency and overtime.
- Increasing levels of sick absence increases pressure on those staff who remain at work.
- Levels of service change likely to affect health and wellbeing with most likely impact on mental health and stress related sickness.

How do we compare with our peers?

- The latest 12 month cumulative differential between ABMU and the all-Wales performance is 0.58%.
- The latest differential between our monthly sickness absence rates and the all-Wales average is 0.79%.

OUR STAFF AND RESOURCES: PEOPLE IN WALES CAN FIND INFORMATION ABOUT HOW THEIR NHS IS RESOURCED AND MAKE CAREFUL USE OF THEM

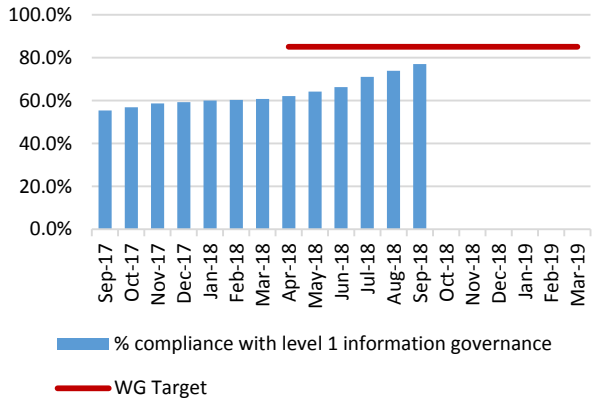
Measure 1: % compliance for the completed level 1 Information Governance (IG) (Wales) training element of the Core Skills and Training Framework
Measure 2: % compliance for all completed Level 1 competencies within the Core Skills and Training Framework

Corporate Objective : Securing a Fully Engaged and Skilled Workforce	**Executive Lead :** Hazel Robinson Director of Workforce & OD
Outcome Statement : Quality trained staff who are fully engaged in delivering excellent care and support to me and family	

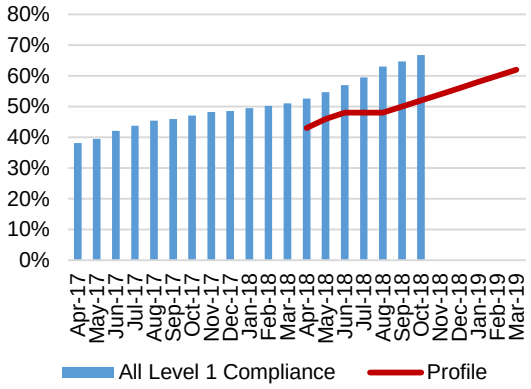
Period : September 2018	**IMTP Profile Target :** (2) 50%	**WG Target :** (2) 85%	**Current Status :** ✗	**Movement :** ↑ ● Improving

Current Trend: Sep 17 - Sep 18

Measure 1: % compliance for the completed level 1 Information Governance (Wales) training

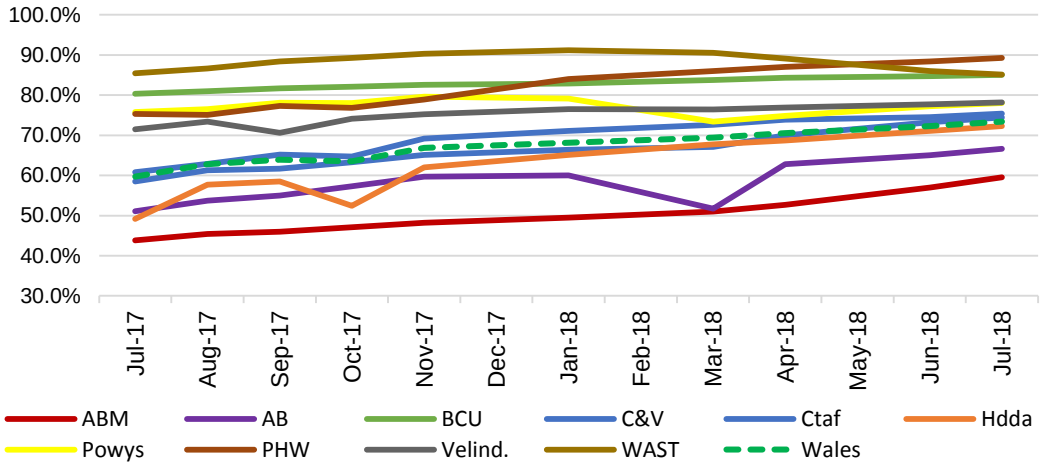


Measure 2: % compliance for all completed Level 1 competencies within the Core Skills and Training Framework



Benchmarking

Measure 2: % compliance for all completed Level 1 competencies within the Core Skills and Training Framework



Source : NHS WALES OUTCOMES FRAMEWORK, ALL WALES PERFORMANCE SUMMARY (October 2018)

Measure 1: % compliance for the completed level 1 Information Governance (Wales) training element of the Core Skills and Training Framework
Measure 2: % compliance for all completed Level 1 competencies within the Core Skills and Training Framework

How are we doing?

Information Governance

- The Current Compliance for Information Governance (IG) Level 1 training is 77%, a 40% increase since September 2017. This is a result of awareness raising via the Information Governance Board Leads, bulletins, IG intranet pages, the appointment of a dedicated IG Training Lead, continued support with e-learning sessions, train the trainer sessions and dedicated face to face sessions held across the Health Board. Proactive targeting of non-compliant staff has taken place via monthly checks on all staff, complemented by checks on staff with access to four major clinical systems against IG training compliance. A supplementary ESR user guide specific for accessing IG e-learning has been well received.

All Level 1 Competencies

- The current level of compliance for Mandatory and Statutory stands at 66.27%. This is an improvement on the compliance level in June 2018 which was 58.78%. A continuation of proactive targeting of non-compliant staff has worked since June 2018 to ensure the compliance level has risen. The support that the health board lead for ESR & Mandatory & Statutory compliance, has provided through e-learning workshops and over the phone trouble shooting has been attributable to the percentage increase.

What actions are we taking?

Information Governance

- Continue to send compliance lists for IG Training compliance to directorates and service delivery units.
- Continue to target staff with clinical systems access who are not IG training compliant
- Continue to deliver E Learning Training Sessions across the Health Board.
- Continue to report IG training compliance formally to the Information Governance Board and to Audit Committee, as well as include it in the annual public facing SIRO Report
- Continue to proactively contact all IG training non-compliant staff individually
- Production of an IG training video as an alternative to eLearning or face to face sessions

All Level 1 Competencies

- Investigate Inter Authority Transfer Process to ensure records transfer with employees.
- Update outstanding individual records from Action Point.
- Use additional resources such as apprentices to reduce the backlog on Action Point
- Continue to deliver e-learning workshops across the Health Board
- Investigate where compliance in higher level training mitigates the need for level 1 training and implement automatic sign off of competencies.

What are the main areas of risk?

All level 1 Competencies

- ESR self-service and supervisor self-service roll out and usage.
- IT infrastructures.
- Potential changes to pay progression and increments.
- Lack of resources (highlighted at Audit Committee).
- Lack of computer literacy amongst staff
- Time and access to computers for community based staff
- Priorities of completing M&S training in relation to completing day to day job related tasks.

How do we compare with our peers?

All Level 1 Competencies

- ABMU have showed consistent improvement over the 12 month period reflected. ABMU show the lowest compliance for the 10 core skills Mandatory Training Framework.

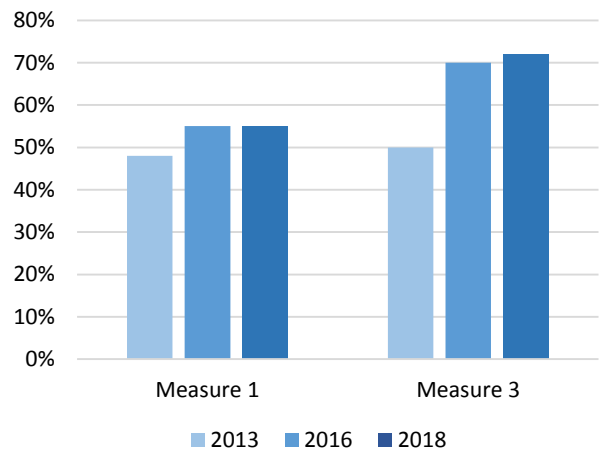
OUR STAFF AND RESOURCES: PEOPLE IN WALES CAN FIND INFORMATION ABOUT HOW THEIR NHS IS RESOURCED AND MAKE CAREFUL USE OF THEM

Measure 1: % of staff who have had a performance appraisal who agree it helps them to do their job
Measure 2: Overall staff engagement score – scale score method
Measure 3: % of staff who would be happy with the standard of care provided by their organisation if a friend or relative needed treatment

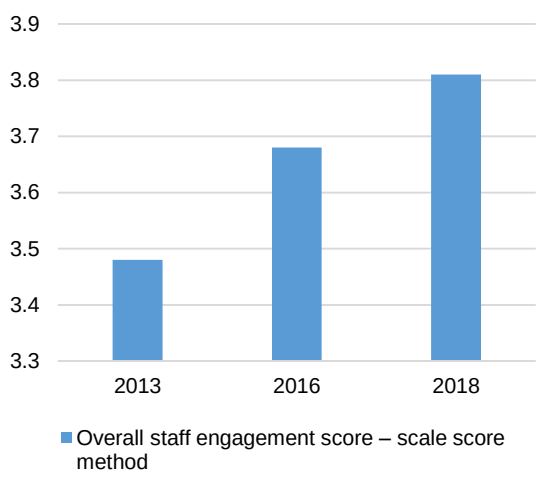
Corporate Objective : Securing a Fully Engaged and Skilled Workforce			**Executive Lead :** Hazel Robinson Director of Workforce & OD	
Outcome Statement : Quality trained staff who are fully engaged in delivering excellent care and support to me and my family				
Period : 2018	**IMTP Profile Target :** N/A	**WG Target :** (1,2,3) Improve	**Current Status:** ✓	**Movement :** ↑ Improving

Current Trend: 2013, 2016 & 2018

Measures 1 & 3

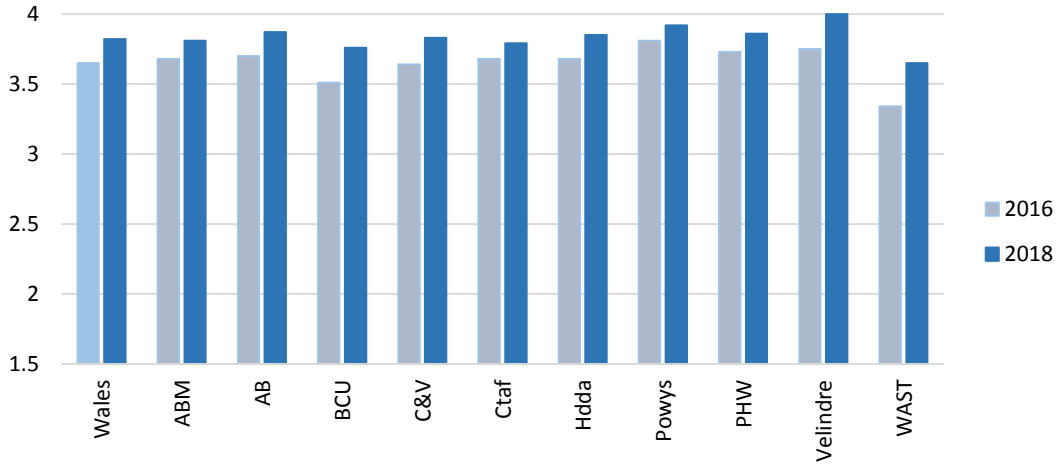


Measure 2



Benchmarking

(2) Overall staff engagement score – scale score method



Source : NHS WALES OUTCOMES FRAMEWORK, ALL WALES PERFORMANCE SUMMARY (October 2018)

Measure 1: % of staff who have had a performance appraisal who agree it helps them to do their job
Measure 2: Overall staff engagement score – scale score method
Measure 3: % of staff who would be happy with the standard of care provided by their organisation if a friend or relative needed treatment

How are we doing?

- Overall the results for ABMU continue to show positive improvements in most areas, and these improvements follow closely NHS Wales' overall results.

- ABMU has seen significant improvement in the following questions:
  - My line manager gives me clear feedback on my work (+12%)
  - In the last 12 months, have you had a Personal Appraisal and Development Review (PADR)? (+13%)
  - I am able to make improvements in my area of work (+14%)

What actions are we taking?

- Staff Experience and OD will host a series of workshops in November 2018. The workshops are for all staff to get involved to help shape ABMU's future. With the results of the NHS Wales Staff Survey in mind, as well as with the overall direction of the organisation, colleagues will identify ways to enhance staff and patient experience.
- All of the information collected during the workshops will be showcased in December for a wider input. Staff will also have the opportunity to contribute online.
- Draft action plans at the organisational level will be shared with stakeholders in January 2019. The Executive Team will endorse actions and measures for success, and share with all colleagues.
- There is the possibility of some actions being identified at the national level, with the assumption that all health boards and trusts would take part in it.

What are the main areas of risk?

- Across NHS Wales there has been an increase in staff identifying that they have personally experienced harassment, bullying or abuse at work from managers / line managers / team leaders or other colleagues. Some actions will be established at the local level in that area and we are anticipating some national actions as well.

- Below are examples of questions where results were more negative:
  - In the last 12 months have you personally experienced harassment, bullying or abuse from managers/line managers/team leaders or other colleagues (20% in 2018; 16% in 2016 for an increase of 4%)
  - In the last three months have you ever come to work despite not feeling well enough to perform your duties? (65% in 2018; 59% in 2016 for an increase of 6%)
  - During the last 12 months have you been injured or felt unwell as a result of work related stress? (35% in 2018; 28% in 2016 for an increase of 7%)

How do we compare with our peers?

- The employee engagement index is typically used to gauge the commitment and motivation of employees towards their organisation. The NHS Wales employee engagement index is made of seven questions that are repeated in each survey to measure trends, and is measured on a scale of five points.
- The engagement index score for ABMU has improved from 3.68 in 2016 to 3.81 in 2018; while NHS Wales engagement index score increased from 3.65 in 2016 to 3.82 in 2018. In general, AMBU's engagement index score is comparable to other health boards of similar size and services offered.

10. NHS WALES SELF ASSESSMENT TEMPLATES

10.1 Accessible Communication and Information for People with Sensory Loss

NHS Organisation	Abertawe Bro Morgannwg University Health Board
Date of Report	October 2018
Report Prepared By	Alison Clarke Sian Jones

The All Wales Standard for Accessible Communication and Information for People with Sensory Loss sets out the standards of service delivery that people with sensory loss should expect when they access healthcare. These standards apply to all adults, young people and children.
Reporting Schedule: Progress against the organisation's action plan for the current operational year is to be reported bi-annually. This form is to be submitted on 31 October and 30 April.
Complete form to be returned to:
hss.performance@gov.wales

Does the organisation have an action plan in place to implement the All Wales Standard for Accessible Communication & Information for People with Sensory Loss?

Yes the Health Board has an action plan.

The All Wales Standards provide the focus for positive action and also highlighted the current gaps for our services users and stakeholders with sensory loss.

Our Sensory Loss Standards Group comprises representation from NHS clinical and managerial staff, voluntary organisations and patient representatives.

Update on the Actions to Implement the All Wales Standards for Accessible Communication & Information for People with Sensory Loss:

Needs Assessments	Key Actions Achieved during 2018-19	Risks to Delivery	Corrective Actions
All public & patient areas should be assessed to identify the needs of people with sensory loss	Members of the Sensory Loss Standards Group have reviewed the audit tool and have identified a small team from within the group, comprising both Service users and staff members to undertake the audit to check progress against the standards. Engagement from Primary care has resulted in an agreed way forward to implement the audit in the Beacons Centre in Swansea.	Ability to expand and implement the audit in new clinical areas, cooperation and participation of teams is essential in clinical areas. Disproportionate focus of audits undertaken in secondary care settings Capacity of staff and time required to undertake the audit. Engagement from the Estates department.	Engagement with primary care settings to undertake the audit. Review of the current audit tool in collaboration with service users, third sector and Health Board staff to assess ease of use.

Needs Assessments	Key Actions Achieved during 2018-19	Risks to Delivery	Corrective Actions
		Confirmation of a date to undertake the audit that is suitable for service users and staff representatives.	
	It has been agreed that an audit of Singleton Hospital Ophthalmology Department will be undertaken. Planning and preparation for this is to commence.	Capacity of staff and time required to undertake the audit	Support provided from members of the Sensory Loss group to complete this action
	Collaboration with the Dementia Training Team has resulted in sharing of information and learning in relation to hospital signage and coloured toilet seats. Environmental audits have taken place and the results are being shared with the Sensory Loss Group.	Inconsistent attendance at the group meetings due to Dementia related workload.	Request briefings to feedback to Sensory Loss group and share learning across departments via Q&S meetings.
	Disability Reference Group (DRG) conducted access visit to Neath Port Talbot Hospital.	Corrective actions to improve accessibility taking place.	Recommendations made to improve accessibility. Neath Port Talbot Hospital considering implementation.
All public information produced by organisation should be assessed for accessibility prior to publication.	ABMU Disability Reference Group reviewed all terminology for signage at Morriston Hospital as well as agreeing pictograms to be used alongside descriptors, resulting in new signage being put in place in Phase 1B. ABMU Disability Reference Group developed guidance for Health Board on signage – distributed to Capital & Estates department for implementation		

Needs Assessments	Key Actions Achieved during 2018-19	Risks to Delivery	Corrective Actions
	Feedback from patient experience reporting as lead to improved signage in certain areas of the hospital. Inconsistent approach to the provision of accessible publications. Standards for production of information for the public developed by ABMU Disability Reference Group and signed off by Health Board.	Cost of production of the materials required to improve signage. Lack of understanding by staff of the statutory obligation to provide information in accessible formats.	Larger font required for hospital signage – signs replaced Produce intranet article on the need to provide accessible information. Review information relating to the booking of interpreters.

Standards of Service Delivery	Key Actions Achieved during 2018-19	Risks to Delivery	Corrective Actions
Health Prevention (Promotion Screening, SSW, Flu Vaccination, Bump Baby & Beyond). Priority areas include:			
➢ Raising staff awareness	During ante natal and the birth visit the Healthy Child Wales programme (HCSP) assesses all the medical and social needs of both parents including sensory loss. A Care plan is developed to ensure clients have access to interpreters/sign language. Staff have had training in delivering the HCWP. Staff awareness raising takes place at professional meetings and skills training sessions.	Availability of interpreters.	Use of external providers for economies of scale and easy access
➢ Ensuring all public information is accessible for people with Sensory loss	Staff use texting as well as other forms of communication to ensure clients understand information and interventions provided. Information leaflets provided by Public	If interpreters or access to Ipads are not available. No braille information is currently available re:	Staff ensure resources are available by planning and booking interpreters for planned appointments.

Standards of Service Delivery	Key Actions Achieved during 2018-19	Risks to Delivery	Corrective Actions
	Health Wales are given to all parents/carers of eligible children re: Fluenz programme.	Fluenz or Height, Weight and Vision Screening programmes, or the Child Measurement Programme.	Awaiting response from Public Health Wales.
➢ Accessible appointment systems	Home visits by the Health Visitor allow for two way communication of appointments. Ongoing appointments are discussed and acceptable ways for clients negotiated to ensure they have an understanding of appointments. ABMU is part of a National Task & Finish Group for school entry hearing screening.	If interpreter not available. If information cannot be produced in an appropriate accessible format.	Staff ensure resources are available by planning and booking interpreters' sign language staff for planned appointments. Support sought from Third sector partners where information is available in an accessible format. Access to the Editorial Advisory Group to provide advice ensuring information leaflets are available and meet the standards.
➢ Communication models	Health Board staff work in collaboration with Specialist teachers/classroom assistants in Units and support School Nurses as necessary if the parents or pupil has a sensory loss issue. Texting appointment details and alerts.	No teacher available.	Re-arrange school visit.
Primary and Community Care. Priority areas include:			
➢ Raising staff awareness	Sensory Loss Awareness training, has been identified to be of high importance. Discussion is underway to facilitate the provision of electronic and direct	Lack of understanding by staff of the statutory obligation to meet the standards for sensory Loss.	E-learning module, intranet article, engagement with third sector to showcase at HB conferences, open days etc.

Standards of Service Delivery	Key Actions Achieved during 2018-19	Risks to Delivery	Corrective Actions
	learning and increase awareness for frontline staff. There is the ambition that 'sensory loss champions' could be identified to support staff or service users when required. Podiatry & Orthotic staff are aware of interpreter service, central resource e-mail address and central telephone line and signpost patients with sensory loss accordingly. Staff in the Orthoptic Dept have completed the on line sensory loss training. All Maesteg Hospital A&C staff have undertaken the e-learning module on sensory loss. All Chronic Pain & MCAS Staff are informed of interpreter services and how to access these. Audiology staff have regular 'deaf awareness' training, and interpreter services are used routinely The pilot of a BSL video to support reception staff meet and greet deaf people is being developed by the NHS Centre for Equality and Human Rights and will be evaluated for its effectiveness at 6 and 12 months. The video will be made available to the Health Board. The Primary Care Quality & Safety Group have invited a	Video unavailable Health Board not being able to access the resource via YouTube. Inability for a rep to attend the forum.	Contact project lead for update. Advise of a different platform that will be required in order for staff to be able to access. Acquire meeting dates ahead of time so that appropriate representation can be sought.

Standards of Service Delivery	Key Actions Achieved during 2018-19	Risks to Delivery	Corrective Actions
	representative of the Sensory Loss Group to participate in the meeting, to support raising of the standards and improving awareness of Sensory loss in Primary Care.		
➢ Accessible appointment systems	Evidence provided of services offering communication via telephone, text and e-mail for appointments i.e. Audiology patients are able to communicate via text, email and telephone. Speech & Language Therapy offer appointments by telephone and post only. There is no access to text messaging. Podiatry and Orthotics do not currently use text service, however the option to communicate by text is being explored. Chronic Pain service uses phone, text and e-mail. MCAS uses phone and e-mail. Text is available from October 2018. Patients attending the Bridgend Eye Unit/Orthoptic Dept are able to access the booking office by e- mail.	Inconsistency of approaches across Health Board. Competing priorities for services.	Share good practice between services. Ensure staff and managers aware of statutory obligation.
➢ Communication models	Services have access to British Sign Language Interpreters to support service users. Evidence across a number of services of having developed and implemented communication for appointments via	Availability of interpreters.	Staff ensure resources are available by planning and booking interpreters for scheduled appointments

Standards of Service Delivery	Key Actions Achieved during 2018-19	Risks to Delivery	Corrective Actions
	telephone, text and e-mail but this remains inconsistent across the organisation. MCAS will be using text service from October 2018. **Loop systems** are available in: Audiology Clinics and Cwmavon Health Centre. Speech & Language Therapy has access to interpreters and employs a generic e-mail account. Loop systems in Podiatry and Orthotics are available including hospital sites and Port Talbot Resource Centre. Chronic Pain & MCAS are mostly community based and a portable hearing loop system is available for use. Maesteg Hospital has a hearing loop. Bridgend Eye Unit/Orthoptic Dept has a portable hearing loop at the reception desk and another available for use in the clinic rooms.	No loop systems currently available in Community Clinic sites; Dyfed Road hub and Speech & Language Therapy. Funding for new system and maintenance/replacement of old equipment. Infrequent usage of the service can result in staff being unfamiliar with the equipment.	Raise awareness of this in annual plan and risk assessment. e-learning training package to support sensory loss awareness across the workforce.
Implementation of the Accessible Information Standard	The Sensory Loss Accessibility Working Group supports and facilitates the raising of awareness and engagement of services in Primary Care to be informed of the Accessible Information Standard.	Capacity to undertake the audit.	Audit of clinical areas against the standards.
Secondary Care. Priority areas include:			

Standards of Service Delivery	Key Actions Achieved during 2018-19	Risks to Delivery	Corrective Actions
➢ Raising staff awareness ➢ Communication models ➢ Accessible appointment systems	Informatics Senior Managers received sensory loss training from Deafblind Cymru, and Royal National Institute of Blind People (RNIB) The Lymphoedema clinic is now employing Oracle to book interpreters, in particular for patients who have suffered head and neck cancer. The service is currently piloting the text messaging service to remind patients of appointments. Patient appointments can be issued via letter or if required more bespoke methods have been used to issue appointments in person. Interpreter services are booked in advance of the appointment. Patients are also provided with leaflets and video applications about lymphoedema, and lymphoedema management & treatment to enhance the different ways information is provided to patients, other than verbally from clinicians. ACCESSIBLE APPOINTMENT LETTERS: The Health Board is continuing to work with service users with visual impairment to develop a method to receive large print outpatient appointment letters. The appointment letter will be put into PDF format and then e-mailed to the patient. Work	Ability to provide training to all staff groups. Ability to refresh staff awareness of sensory loss. Some patients may not have an e-mail address so would be unable to participate in the pilot.	Consider that e-learning training in sensory loss is made mandatory. Active support and involvement of the IM&T department has been secured and the pilot will be evaluated to inform future action.

Standards of Service Delivery	Key Actions Achieved during 2018-19	Risks to Delivery	Corrective Actions
	continues on this pilot with regular feedback at Sensory Loss group meeting. The IM&T department is awaiting suggestions from our deaf colleagues as to the content of the letter to make it user friendly and encourage sign up. ACCESSIBLE CONSULTATIONS: ABMU carried out a successful Face Time trial using iPads to provide real-time signing for deaf people whose first language is British Sign Language and who are receiving care in hospital. The Face Time trial was developed as part of ABMU's wider mobilisation project, which involves using new technology to improve contact between the health board, staff and patients. When it is made more widely available it will not replace face to face interpretation but will instead be an extension of the existing service. This opportunity has been extended to a pilot within Neath Port Talbot Outpatient Department. HEARING LOOPS: A mapping exercise of the availability of hearing loops across the Health Board has been undertaken. Data has been collated and a gap analysis report will be presented at the Quality & Safety Forum.	Availability of feedback to inform the project, until this has been received it is not possible to commence the pilot. Access to the appropriate technology and awareness of the service across all hospital sites and clinical areas. The innovative practice is not requested or actively pursued. Staff turn-over may result in the knowledge of the technology and service being forgotten. Report not completed. Report not presented at Q&S forum. Ability to sustain raising	Contact service users for feedback and guidance. The use of Social Media, Internet and Intranet to communicate this alternative approach and its success placing patient experience at the centre of the evaluation. Refresh the awareness raising of this innovative practice to the Delivery Units. Chase report author. Timetable the report as an item on the Q&S forum agenda

Standards of Service Delivery	Key Actions Achieved during 2018-19	Risks to Delivery	Corrective Actions
	ENGAGEMENT: ABMU continues to engage with a range of stakeholders this includes local representatives from disability access groups, RNIB Cymru and local RNIB groups, British Deaf Association, Bridgend and Swansea Deaf Clubs, Wales Council for the Deaf, Deaf Blind Cymru and Action on Hearing Loss Cymru. The ongoing engagement takes place through ABMU's Sensory Loss Standards Group, Disability Reference Group, Deaf Focus Group and Stakeholder reference Group.	awareness and maintaining awareness of the standards and best practice.	Organise awareness raising events and increase use of social media in collaboration with our third sector partners, service users and community groups to raise and sustain awareness to achieve further improvement.
	Outpatient departments access British Sign Language Interpreters via Oracle to support service users.	Having the information that a patient requires an interpreter.	Ensure referral has required information to inform the decision about Sensory loss requirements. Capture information on the PAS.
	British Sign Language interpreters are integral to the success of the Sensory Loss Working Group and are commissioned to provide a service at the meeting.	Availability of interpreters.	Book interpreters service well in advance of meeting. Review contract with WITS further to engagement with local Deaf Focus Group.
	A service provided by the Volunteer service for adult hearing aid users has been developed and implemented in partnership with Action on Hearing Loss. A nationally agreed pathway for battery provision and ongoing hearing aid maintenance,	Availability of Volunteers or changes to the Volunteers service in the health board.	Engagement with the Lead for Volunteers in ABMU HB to ensure a sustainable service.

Standards of Service Delivery	Key Actions Achieved during 2018-19	Risks to Delivery	Corrective Actions
	including self-management, battery management and volunteer peer support is now being run out of Singleton hospital.		
Implementation of the Accessible Information Standard	The Sensory Loss Accessibility Working Group supports and facilitates the raising of awareness and engagement of services in Secondary Care to be informed of the Accessible Information Standard.	Capacity to undertake the audit.	Audit of clinical areas against the standards.
Emergency & Unscheduled Care. Priority areas include:			
➢ Raising staff awareness ➢ Communication models	IN-HOURS/OUT OF HOURS: Wales Council for Deaf People shares information with the Health Board in relation to accessing interpreters in an emergency situation.	Out of Hours Service support may not always be as comprehensive as in-hours.	Raise awareness of other models to improve communication in times of emergency including the WAST app.
Concerns & Feedback (CF). Areas include:			
➢ Highlighting current models of CF in place which would support individuals with sensory loss to raise a concern or provide feedback	Texting, braille version information on how to raise a concern. Easy read leaflets on how to raise a concern and information on Putting Things Right for concerns. Audio version on how to raise a concern. Using suitable font for corresponding with complainants with visual issues. A British Sign Language video version of the patient complaints information leaflet is available on the ABMU's website for BSL users to access to support in raising a concern.	Complacency with models familiar with and lack of modernisation and use of digital technologies to improve communications in this area. Poor information and limited reporting of data on Sensory loss complaints via Datix. Reduced awareness of number of complaints and themes.	Horizon scan and access up to date information on new systems and devices employed to improve services in this field. Through improved data collection and reporting in Patient Experience and Datix review themes and trends relating to sensory loss and produce action plan.

Standards of Service Delivery	Key Actions Achieved during 2018-19	Risks to Delivery	Corrective Actions
	Let's Talk, one of ABMU's feedback mechanisms, includes a text message and email service to notify the Health Board of issues / provide the Health Board with positive and negative feedback on its services. Bridgend Boundary Change will impact on group membership for the Sensory Loss Accessibility Working Group.	Loss of experienced staff with appropriate knowledge and skills in this field.	Recruit new members prior to April 2019.
➢ Highlight any CFs received in sensory loss and actions taken	Difficulty reading appointment letter, font size increased to improve accessibility of information.	Staff not always aware of patients' sensory loss when booking patient.	E-mail project to continue.
Patient Experience*	**Key Actions Achieved during 2018-19**	**Risks to Delivery**	**Corrective Actions**
Mechanisms are in place to seek and understand the patient's experience of accessible communication and information	The All Wales survey is used to seek and understand the patient experience of accessible communication and information. Representatives from BDA Wales, Action on Hearing Loss Cymru, Deaf Blind Cymru and RNIB Cymru comprise the membership of ABMU's Sensory Loss Group. Service users experience is shared at the meeting to inform gaps and areas for improvement. The BDA and RNIB are also represented on ABMU's Disability Reference Group. People with sensory loss are actively engaged in department audits relating to the		Any concerns are identified and logged on Datix. 'You said – We Did' forms are also completed and reported in Quality and Safety forums in each Unit.

Standards of Service Delivery	Key Actions Achieved during 2018-19	Risks to Delivery	Corrective Actions
	Sensory Loss standards and their experiences communicated to staff. Sensory Loss Training has been provided for staff in the Informatics Department to support future work/developments relating to making appointment letters more accessible to people with sensory loss. Training provided by third sector organisations. The sensory group facilitates the opportunity to receive service user feedback; Issues highlighted by a patient with hearing difficulties was lack of communication methods within Primary and Secondary Care. Patients are required to respond to hospital appointment letters via telephone as no e-mail address is provided. The service user then has to visit the hospital to make any changes to the appointment. There are ongoing issues with obtaining a portable hearing loop in some parts of the Health Board. Patient praised the superb efforts of a GP who made changes to facilitate patients' use of services; the patient put the GP forward for an ABMU award for exceptional service.	Increased DNA rates, poor patient experience, patient does not receive the care required. Limited staff awareness. Availability of funding and access to training.	Provide e-mail access for appointments to patients with sensory loss, continue engagement with IM&T. Health Board is working to ensure that hearing loops are available and that staff are trained to use them. Intranet articles to raise profile of different conditions.

Standards of Service Delivery	Key Actions Achieved during 2018-19	Risks to Delivery	Corrective Actions
	Service user feedback has indicated that the HB should be cognisant of other professionals such as Lip speakers and Palantypists (more correctly known as Speech-to-Text Reporters) and Deafblind interpreters indicating a fuller understanding of the variety of needs of persons who have acquired deafness, Auditory Processing Disorder or dual sensory loss as well as the more well known issues. A service user has highlighted that the HB should recognise carers with a sensory loss and that support should also be provided to people with sensory loss who may be attending an appointment in the capacity of a carer or as the parent of a child. Dyfed Road GP Surgery, Neath has implemented an electronic scrolling sign that details the patient's name, the doctor/nurse they are to see and the appropriate room number. The customer care and interaction provided by reception staff at NPT, Morriston and Singleton Hospitals has been praised by patients who had a hearing and visual loss. However there is also feedback relating to attitude of professionals and the need for	Patient may DNA or vital information may not be understood by carer.	Investigate opportunities to employ new technologies. Developing links with regional carers associations as most carers associations have newsletters etc. and might insert an information item.

Standards of Service Delivery	Key Actions Achieved during 2018-19	Risks to Delivery	Corrective Actions
	education of the workforce to better manage people with sensory loss.		
The key themes to emerge from patient experience feedback (both positive and negative)	Awareness training for staff on sensory loss Access to hearing loops There is a continued requirement to provide information in a more accessible format e.g. large, bold print, with appropriate contrast. Departments should provide more accessible information and a variety of ways in which the service can be contacted, particularly e-mail and text messaging. Problems with lighting and flooring in POWH Eye Clinic raised at Disability Reference Group. Problems with flooring in corridors at POWH identified by DRG Lack of blue badge spaces adjacent to Children's Centre at POWH identified by DRG Lack of drop curbs identified on route from bus stop to POWH entrance		Provide different awareness training options for staff, face to face training, e-learning, drop-ins. Complete hearing loop mapping report, present at Q&S and raise awareness at Unit level IT Department is piloting large print appointment letters. This would be an interim measure until a national solution is implemented. Advised to include other communication options in appointment letters. DRG agrees use of capital monies allocated to improve access to our facilities – Lighting and flooring replaced Flooring replaced with advice from DRG representatives Work underway to redesignate spaces to increase number of blue badge spaces Being addressed using capital allocation

* **Patient experience mechanism and themes to be documented in this return applies specifically to patients with sensory loss who have accessible communication and information needs**. There is a requirement in the NHS Delivery Framework for NHS organisations to provide an update on patient experience for all patients (not just for those with accessible communication or information needs). This is to be reported on a separate proforma entitled 'Evidence of how organisations are responding to patient feedback to improve services' and links to the NHS Framework for Assuring Service User Feedback.

10.2 Advancing Equality and Good Relations

NHS Organisation	Abertawe Bro Morgannwg University Health Board
Date of Report	15 October 2018
Report Prepared By	Joanne Abbot-Davies, Jane Williams, Nicola Johnson

The Public Sector Equality Duty seeks to ensure that equality is properly considered within the organisation & influences decision making at all levels. To meet the requirements of the Equality Act 2010 (Statutory Duties) (Wales) Regulations 2011 Health Boards & NHS Trusts must consider how they can positively contribute to a fairer society through advancing equality & good relations in their day-to-day activities. The equality duty ensures that equality considerations are built into the design of policies & the delivery of services and that they are kept under review. This will achieve better outcomes for all.
Reporting Schedule: Progress against the organisation's plan is to be reported bi-annually. 31 October and 30 April.

Does the organisation have a Strategic Equality Plan (SEP) in place, setting out how tackling inequality and barriers to access improves the health outcomes and experience of patients, their families and carers?	**Yes**
Does the SEP include equality objectives to meet the general duty covering the following protected characteristics: age, disability, gender reassignment, pregnancy and maternity, race (including ethnic or national origin, colour or nationality), religion or belief (including lack of belief), marriage and civil partnership, sex, sexual orientation?	**Yes**

Update on the actions implemented during the current <u>operational year</u> to advance equality & good relations in the health board's day to day activities

	Key Actions Planned	**Risks to Delivery & Corrective Actions**	**What was achieved**
Planning & Performance Management			
IMTPs clearly demonstrate how the NHS organisation meets the duties associated with equality & human rights and the arrangements for equality impact assessment.	Ensure we meet the commitment within our Annual Plan to assess the equality impact of proposed service change.	Risk: Equality Impact Assessment (EIA) may not an integral part of the service change processes. Training and coaching provided to key service managers. The HB identified that we have a skills and capacity gap to impact assess complex service change. We secured an external expert on secondment from Welsh Government to support the Service Remodelling Workstream. Ongoing arrangements are in	Equality impact assessment has been integrated into the work of the Service Remodelling Workstream. EIA used to inform the Board decision on Tranche 1 of the schemes and also phase 1 EIAS completed for Tranche 2 schemes. The external expert has developed a library of information to be used in future EIAs. Links to the new Quality Impact Assessment process

	Key Actions Planned	Risks to Delivery & Corrective Actions	What was achieved
		the process of being agreed and this will include EIA at an earlier stage of our corporate planning processes.	that the Service Remodelling Workstream has also put in place.
Steps have been taken, where possible, to align equality impact & health needs assessments to ensure they take account of the 'protected characteristics' & utilise specific data sets & engagement activity.	Develop an Area Plan for Western Bay & establish monitoring against actions.	The equality impact assessment for the Western Bay Population Assessment 2017 identified that there is greater insight into the care and support needs of some people with protected characteristics than others. Further research is needed to address the data gaps.	Lessons learnt workshop held on preparation of Population Assessment & Area Plan – info collated to support future improvement work. Plan developed to refresh Population Assessment and Area Plan on new Western Bay footprint after Bridgend Boundary change
IMTPs set out how equality impact assessment is embedded into service change plans & informed by the findings from engagement & consultation and other evidence.	Continue to undertake equality impact assessments on proposed service changes and use the results of our assessments to inform decision making.	Risk: Board may not take decisions in light of impacts on protected groups. Risk: Service Delivery Units may not understand the need or importance of carrying out EqIAs. Risk: Individuals across Health Board may not have the experience, training or skills to develop EqIAs. Further EIA training is also being planned for the Planning Team and key managers in Delivery Units. The IMTP will be Equality Impact Assessed in tandem with our Organisational Strategy and Clinical Services Plan.	Refresher training was provided for service delivery units undertaking equality impact assessment in late 2017 with ongoing support available. Deficits in skills led to secondment of EqIA specialist to support Health Board in developing EqIAs and providing central information resource. Equality impact assessment training was delivered on 22.02.2018 as part of the Board development session. Further training will be carried out in Nov/Dec 2018. The external specialist has developed a library of information that can be used in future EIAs.
Service plans include clear	Engage with the public and partners to develop	Risk: Lack of availability of time /	Engagement undertaken to inform

	Key Actions Planned	Risks to Delivery & Corrective Actions	What was achieved
measurable objectives for reducing health inequalities & are aligned to the equality priorities set out in the Strategic Equality Plan.	a strategic framework for mental health The Annual Plan 2018/19 sets out our approach and priorities for reducing health inequalities.	skills to support co-designed and co-produced engagement process across Health Board and Local Authorities. All of the actions in the Annual Plan to be tracked through quarterly reporting to the Board.	the Health Board and Local Authorities' Strategic Framework for Adult Mental Health. 105 people gave their experiences face-to-face and another 170 through questionnaires. Quarter 1 report on the delivery of the Annual Plan has been approved by the Board.

	Key Actions Planned	Risks to Delivery & Corrective Actions	What was achieved
Governance			
The Health Board/NHS Trust receives assurance that processes are in place to identify Equality impact, undertake engagement and that mitigating actions are clearly set out. Committee or Sub-committees confirm that equality impact assessments inform decision making.	Review the reporting arrangements to provide assurance on equality.		Reporting arrangements clarified as part of the overall review of the Board Sub Committee structure. The Service Remodelling Workstream has EqIA as a standing item on the agenda and ensures they are completed for all service changes within the programme. All proformas on proposed service change for CHC include a section on EqIA
The Health Board/NHS Trust ensures that equality considerations are included in the procurement, commissioning and contracting of services.	Deliver equality training to the Procurement Team.	Two training sessions were held in the Procurement offices at an agreed time and date to overcome the risk of low numbers of staff being released for training.	All members of the Procurement Team attended equality and human rights training delivered by the NHS Centre for Equality and Human Rights.
Quality and safety			

	Key Actions Planned	Risks to Delivery & Corrective Actions	What was achieved
Each service change programme/plan as a minimum includes: equality implications, including positive and negative impacts on patients, public and staff and mitigating actions to reduce any anticipated negative impact.	Ensure we meet the commitment within our Annual Plan 2017/18 to assess the equality impact of proposed service changes.	Risk: EqIA not seen as integral part of planning service change. Training and coaching provided to key service managers. The Health Board identified that we have a skills and capacity gap to impact assess complex service change. We secured an external specialist on secondment from Welsh Government.	Equality impact assessment has been integrated into the work of the Service Remodelling Workstream.
Equality is clearly linked to quality initiatives and are informed by the needs assessment findings, the risk register, and the challenges and improvement priorities set out in the Annual Quality Statement.	Engage with the public and partners to transform services by improving efficiency, addressing PJ paralysis and so reducing the number of beds required in DGHs and OPMHS.	Risk that public and partners do not understand benefits to quality and reduction of risks through new pattern of services.	Engagement held in early 2018-19 outlining a new pattern of services. EqIA completed as part of this process and amended in light of engagement findings A Quality Impact Assessment process has also been used to assess our complex service changes this year.
Workforce			
There is evidence that employment information informs policy decision making and workforce planning.	Aim to increase the diversity of the workforce	ESR self-service should improve the disclosure rate of protected characteristics for staff. The self- service facility enables staff to update their own details.	We promoted NHS careers / apprenticeships at diversity events, including Swansea PRIDE on 5.05.2018 and NPT BAME event on 2.08.2018. We launched Project SEARCH with Bridgend College and Elite Supported Employment Agency on 13.09.2018. This has enabled nine young people with additional learning needs and disabilities to secure a supported internship at the

	Key Actions Planned	Risks to Delivery & Corrective Actions	What was achieved
			Princess of Wales Hospital.
Numbers of staff who have completed mandatory equality and human rights training 'Treat Me Fairly' (TMF)			10,999

Completed form to be returned to: hss.performance@gov.wales

Relevant Strategies and Guidance

- Equality and Human Rights Commission Wales (EHRC) https://www.equalityhumanrights.com/en/commission-wales
- Making Fair Financial Decisions: Guidance for Decision-makers - Equality and Human Rights Commission
- EHRC's "Is Wales Fairer?" 2015
- Welsh Government Equality Objectives 2016
- Organisations Revised Strategic Equality Plans 2016 - 20
- EIA Practice Hub – NHS CEHR/WLGA 2015 – http://www.eiapractice.wales.nhs.uk/home
- The Essential Guide to the Public Sector Equality Duty: An Overview for Public Authorities in Wales (EHRC)

10.3 Good Work Framework- Dementia Training

Reporting Schedule	30th September 2018
Health Board/Trust	*ABMU HB*
Date of Report	*27th September 2018*
Completed By	*Nicola Derrick*
Contact Number	
E-mail	

Reporting Template: As outlined in the 'Good Work - dementia learning and development framework' all staff who work for NHS Wales need to have a solid awareness of dementia and the issues that surround it, to ensure that their approach supports people with dementia and carers to live well. This reporting template monitors the percentage of employed staff who have completed dementia training at an informed level and the actions being implemented to ensure the appropriate staff groups receive dementia training at a skilled and influencer level. Data is to be sourced from the Electronic Staff Record (ESR).
Target**:** For 2018-19, 85% of staff who come into contact with the public will have completed the appropriate level of dementia/education training.
Reporting Schedule: Dementia training is to be reported bi-annually. This form is to be submitted on 21 October (for data collected at 30 September) and 21 April (for data collected at 31 March).
Form to be returned to:
hss.performance@gov.wales

Data at:	Target	Total number of staff on ESR	Total number of staff on ESR who have completed dementia training at an informed level	Percentage of staff who have completed dementia training at an informed level	Update on issues impacting delivery
30 September 2018	**85%**	16,317	12,138	75.7%	Cancellation of 20 sessions between September 2017 to September 2018 due to insufficient nominations and non-attendance of staff on the day of the event leaving insufficient numbers to run the event effectively. Long Term and Short Term sickness has also effected training offered
31 March 2019	**85%**				

What actions have been implemented to identify staff groups who require dementia training at a skilled and/or influencer level*? What has been put in place to deliver and record training for these groups?
Skilled Level – DCT3-Dementia Care Training Level 3 = 533 staff have completed DCT3 recorded on ESR Influencer Level – Plans to develop an Influencer Training Package for 2019, will look to enlist the assistance of Corporate Learning and Development ensure the training is pitched at the correct level of education for this group of staff

*Further information on the staff groups that are required to complete dementia training at a skilled and/or influencer level and the training topics to be covered are available in 'Good Work - dementia learning and development framework'. https://socialcare.wales/resources/good-work-dementia-learning-and-development-framework

10.4 Implementation of the Welsh language actions as defined in 'More Than Just Words'

NHS Organisation	**ABMU**
Date of Report	**September 2018**
Report Prepared By	**Carol Harry**

Each Health Board and Trust is expected to put in place actions to deliver the strategic framework for Welsh language services in health, social services and social care: 'More Than Just Words'. This has been developed to meet the care needs of Welsh speakers, their families or carers. Actions to deliver the framework are to cover both primary and secondary care sectors. **Reporting Schedule:** Progress against actions to deliver More Than Just Words is to be reported bi-annually. This form is to be submitted on 31 October and 30 April.

Update on the actions to deliver the More than Just Words Strategic Framework

Priority Area	Yes or No	Supporting Evidence		
		Key Actions Achieved	**Risk to Delivery**	**Corrective Actions**
Population Needs Assessment The organisation has identified the Welsh language needs of its population and has used it to plan services.	**Yes**	Population Assessment for the Western Bay region, was launched in April 2017 and will be repeated in 2021 allowing Western Bay partners to incorporate new information and to ensure progress is monitored effectively. We continue to use population assessments to inform how services assess the needs of Welsh speakers and this data is underpinning our strategy for service development. Our grant contracts with the third sector continue to require bodies to set out their approach to bilingual service provision		
Welsh Language Skills The organisation has identified the Welsh language skill levels of its	**No**	Of the 16,000+ staff at ABMU only 546 staff have identified themselves on ESR as having some level of Welsh language skills. Completion of this via ESR is not mandatory but staff with the	Some staff do not have the confidence to use their Welsh language skills with patients. Some staff simply say	We continue to encourage staff to input their language skills into ESR and sites have manually collected this data as a backup. Lunchtime sessions have been held at one of our sites to encourage staff

workforce and is using this information to plan services.		relevant access rights are being encouraged to complete it. In 2017/18, 535 of our 16,000 staff registered an interest in taking the free 10-hour Welsh language course.	they do not wish to use their Welsh Language skills and for this reason have chosen not to display the logo denoting they are bilingual on their uniforms. 36 staff completed the course.	to chat in Welsh that helps to refresh their skills and increase confidence levels. We are encouraging other sites to hold similar sessions. In tandem with the free-on-line Welsh course consideration is being given to joint working with neighbouring health boards to pool Welsh Language tuition resources
Where there are gaps in Welsh language skills the organisation has ensured that vacancies are advertised as 'Welsh language essential'.	**No**	The ABMU Bilingual Skills Strategy requires managers to undertake an assessment of Welsh Language skills to seek to increase the number of 'Welsh Language essential' vacancies. Workforce colleagues are supporting awareness sessions in this regard.	It is difficult to recruit English-speaking candidates to particular specialisms.	We are promoting the free-on line Welsh Language course to encourage existing staff to improve/refresh their Welsh Language skills.
How many members of staff have undertaken a course to learn Welsh or to increase their confidence to speak Welsh during this operational year?				Analysis:- Enrolled on Welsh language Course:- 535 Completed the Course:- 36 Not Started the course:- 278 Currently Undertaking the Course:-221
Patient Preference and Experience The organisation has processes in place to record when an	**No**	Our patient letter templates provide for dual language (i.e. both English and Welsh). By the end of 2018, we plan to have achieved 100 % in terms of patient letters being sent bilingually. We are	There is currently no single method of capturing an individual's language preference in a way that populates	Our ability to comply with the Welsh Language Standards and the 'More than just words' Framework is reliant on NHS Wales Informatics Service (NWIS) ability to provide this function. We

Active Offer has been made and ensure that the language preference of patients is noted across primary and secondary care.		on target to meet this objective. A bilingual appointment reminder via text service is in place across all main ABMU specialities. The default first text received is Bi-Lingual, and from that point forward the patient may specify whether they wish to receive further texts in Welsh/English as they so wish. The 'Myrddin' patient information system has a field to record patient language preference; we currently have 610 patients logged as having indicated their preferred language as Welsh. Our outpatient self-check-in system at Morriston Hospital offers patients a choice of whether to transact in Welsh or English. The language preferences of all inpatients is collected on admission via the Unified Assessment Form	preference across all information systems. Also the solution for language preference may be different from system to system. WPAS (our main patient information system) does not currently have the functionality to capture language preference and produce specific correspondence based on this preference. NWIS need to manage this issue at a national level, to determine whether it should be included within the Electronic Master Patient Index which would then populate all integrated systems with the relevant information in a consistent way	have written to NWIS to raise this issue. .

The organisation has methods in place to communicate to staff the importance of making an Active Offer.	**Yes**	The language preferences of all inpatients is collected on admission via the Unified Assessment Form		
The organisation is mainstreaming experience of Welsh language services as part of the information received/ feedback from patients.		All patient satisfaction surveys are produced bilingually. From May to August 2018 there were 17 surveys returned in Welsh 0.08% of the total received. All 'Friends and Family' reports are produced bilingually and placed on ward/department notice boards next to the English reports All patient condition leaflets are produced bilingually. All complaints received in Welsh receive a Welsh language response. From April 2018 **to October 1st 2018** ABMU received 4 complaints in the medium of Welsh but not regarding the Welsh language. All ABMU staff have access to learn Welsh via the Work Welsh Welcome online course. Staff are encouraged to learn everyday phrases that they can use in conversation with the patient, as often a word of comfort is all that is needed.	Due to the low number of staff with Welsh language skills whilst we endeavour to provide a service Welsh wherever appropriate – if this is not practical (or indeed clinically safe) we explain this to the service user We have a single-handed Welsh Language Translator and default to external providers when demand exceeds internal capacity. This can lead to longer lead-in times for turnaround of translation.	We are seeking to appoint a second in-house translator.

How many patients have been asked their language preference and have had this preference noted on their records?				We have 610 patients that have registered their language preference as Welsh
Commissioned and Contracted Services The organisation ensures that Welsh language considerations are included in the commissioning and contracting of services including primary care services	**Yes**	The Local Framework for the appointment of Contractors and Consultants ensures this and includes the following as a standard:- *The Employer has a Welsh Language Scheme which sets out its various commitments in terms of bilingualism. A copy of the Scheme can be accessed via the website at www.abm.wales.nhs.uk To assist the Employer in delivering upon these important commitments it is important that the Contractor ensures that any materials/signage on display to the public will be bilingual and meet the requirements of the Scheme in terms of their size, layout, format, quality and prominence. In addition, where there is likely to be a direct interface with the public (either by telephone, email, letters or face to face contact), the relevant provisions of the Employer's Welsh Language Scheme must be observed. Advice regarding compliance can be obtained via the Employer's Welsh Language Officer on 01639 683351.*		
Sharing Best Practice Best practice in providing Welsh language services is shared with all		Speech and Language Therapists within our Mental Health & Learning Disabilities Delivery Unit use the 'laith Gwaith' quote mark on clinical correspondence and		

relevant staff in the organisation and the organisation also shares best practice with other health boards and trusts.		reports to help highlight that they are able to deliver a bilingual service. This initiative is being rolled-out across Therapy services across ABMU. In collaboration with Coleg Cymraeg Cenedlaethol, Coleg Gwyr and Swansea University ABMU has been represented at Careers festivals and sessions such as 'Nursing through the medium of Welsh' promoting to local schools and colleges why it is so important that we recruit more staff who are able to provide services through the medium of Welsh. We continue to communicate bilingually in terms of our website, hospital based information screens, our website, patient leaflets and posters as well as through social media. We are continuing to increase the level of Welsh medium reading material in in-patient and outpatient areas. We have held awareness sessions on Welsh language issues for GPs and practice managers and continue to work with them to increase the number of referrals setting out patient language needs. We have redeveloped our staff handbook which has a section on		

		the importance of language awareness We continue to promote the free-online Welsh language course available to all staff. As an organisation we continue to encounter difficulties in recruiting suitably qualified and experienced translators. We are seeking to recruit a Welsh language Translation apprentice		

Completed form to be returned to: hss.performance@gov.wales

10.5 Improving the Health and Well-being of Homeless & Specific Vulnerable Groups

NHS Organisation	ABMU Health Board
Date of Report	October 2nd 2018
Report Prepared by	Tony Kluge, Cluster Development Manager (5 Clusters) Debra Morgan, ABMU HB Planning and Partnerships Support Manager

Health Boards are expected to have in place assessments and plans to identify and target the health & well-being needs of homeless & vulnerable groups of all ages in the local area. **Vulnerable groups are people identified as: homeless, asylum seekers & refugees, gypsies & travellers, substance misusers, EU migrants who are homeless or living in circumstances of insecurity.**
Reporting Schedule: Progress against the Health Board's action plan is to be reported bi-annually. This form is to be submitted on

	Key Actions Achieved April to September 2018	**Key Actions Achieved** October 2018 to March 2019	**Risks to Delivery**	**Corrective Actions**
1. Leadership The Health Board demonstrates leadership driving improved health outcomes for homeless and vulnerable groups.	A multi agency approach has been adopted across ABMU linked to key geographical areas in implementing the standards set out in the Welsh Government's 'Standards for Improving the Health and Wellbeing of Homeless People and Specific Vulnerable Groups'. The Health and Housing Group is currently planning a Western Bay Housing Symposium to be held on October 5th which will focus on exploringemerging		• Lack of multi agency involvement/partnership working • Communication systems fragmented/not joined up	• The need to develop and strengthen the work and profile of HHAVGAP across Swansea, Neath Port Talbot and Bridgend has been flagged and discussed by the Health and Housing Strategy Group • Boundary Changes will come into effect in April 2019 when Bridgend becomes part of Cwm Taf Health Board. There is a need to consider strengthening links with NPT following the end of March 2019 • Western Bay Housing Symposium to be held on October 5th organised by the Western Bay Health and Social Care

	issues for health and social care, funding available for health, housing and social care via the Integrated Care Fund and improving support available for rough sleepers. This symposium will build further on the Vulnerability Workshop held in December 2017			Programme will provide an opportunity to look at emerging issues for Health and Social Care moving forward.
2. Joint Working The Health Board works in partnership with the Local Authority, service users, third sector and stakeholders to improve health of vulnerable groups and contribute to the prevention of homelessnes s.	The HHAVGAP Group continues to meet quarterly in Swansea. Meetings took place on June 13th and September 12th during this reporting period. Updates and discussions have taken place at these meetings related to the development of the homelessness strategy and action plan for Swansea. Local Authorities have been consulting with partners including health regarding the development of their Homelessness Strategy Consultation. The HHAVGAP Group have received regular updates from Swansea Council regarding the strategy and have inputted into the consultation and action plan development. Swansea Council have produced the		• Increasing demand on services • Lack of funding/resource • Lack of multi agency involvement • Systems not 'joined up' projects/initiative s/ • Support mechanisms fragmented	• Membership of the HHAVGAP steering group continues to develop and expand as additional third sector organisations and other interested parties attend and join the group as appropriate. • Innovative use of Cluster Funds/ ICF funds and other funding streams to support Vulnerable Groups locally continues to prove effective. • Events/workshops/co production opportunities to continue to be held as appropriate. • Training opportunities to raise awareness of specific Vulnerable Groups to continue to be offered as appropriate to members of HHAVGAP, GP Practices and other organisations. • Resources developed by HHAVGAP to continue to be shared with partners when relevant and appropriate to need.

	draft documents and the consultation is taking place from 3rd to 30th September. Drop in sessions regarding the consultation took place on September 19th and September 24th. Swansea's plan will go to cabinet on November 15th and be in place by the end of the year. NPT County Borough Council held a consultation event to review the NPT draft Homelessness Plan on September 14th. Feedback was given to the HHAVGAP Group by the Community Health Council group on June 13th following the publication of the report: *Views and Experiences of People who are Homeless/Vulnerably Housed.* This report was also shared with the Health and Housing Strategy Group who are formulating a response. The report flagged the role of the Homelessness Nurse in Swansea as a positive initiative. It was also mentioned that there may be a possibility of extending this role			

	to 7 days a week for Swansea as the Local Authority were investigating funding streams to facilitate this. It was also noted that the service provided for the homeless in Swansea was not currently replicated in Neath Port Talbot and Bridgend. Some respondents living in Neath Port Talbot and Bridgend had travelled to Swansea to see the Homelessness Nurse and access support. Megan Stephens from the Domestic Abuse Hub delivered an overview of the Key 3 Project. Domestic Abuse is a PSB Priority. It can lead to mental health issues including depression. The aim of the project is to ensure that existing services are effectively used and the dots are joined regarding existing support. It was also reported that 'Ask and Act' Training is being rolled out across health. The Women's Refuge Service in the Penderi Network continues to develop. Feedback is actively being sought from			

	Service Users and Key organisations like Women's Aid in the Coming months to determine what is working well and how this Primary Care Service could be further improved. The Penderi Cluster Network Commissioned SCVS to undertake a CYP Consultation on mental health during 2017/18. This report was shared with HHAVGAP in June 2018. Avenues for future exploration have been proposed. Swansea Council and the Health Board have requested data to inform their wellbeing plans. Recommendations will be factored into the Penderi Cluster Plan going forward. Links have been developed with the Gypsy and Traveller Liaison Officer based at Swansea Council who has given an overview of the work that she does. Links have been forged with the Business Support Manager based at the Cwmtawe Cluster Network where both Official and Unofficial sites			

	in Swansea are based. Moves have been made to look at effective support of vulnerable patients within the secure estate at key transition points. Links have been made with the prison health team and the Head of Reoffending. The Head of Reoffending attended HHAVGAP on September 12th and discussed an initiative being introduced for prison officers to work alongside Housing Associations. Links have been made between the HMP Swansea and Housing Options and meetings are taking place with the Homelessness Nurse, Housing Options and the Prison Health Team to consider effective support for vulnerable men at key transition points ie: release. A link has also been made with the Welsh Refugee Council who will be attending the December meeting to outline work they are undertaking to support destitute asylum seekers.			

	Cruse will also attend the December meeting to focus on trauma and services that they are able to offer vulnerable people to support good mental health. The HHAVGAP Group is planning a mental health event that is scheduled for November 1st. Links have been made with Housing and the Mental Health team to outline the current position regarding supporting mental health and plans moving forward. The aim of the session is to ensure that any issues/concerns are flagged regarding mental health and vulnerable groups to ensure the needs of vulnerable groups are included in any planning of services/strategy moving forward.			
3. Health Intelligence The Health Board works in partnership with the Local Authority, service users, third sector and stakeholders and demonstrates an	-Health intelligence is continually strengthened by the contributions made to the HHAVGAP Steering Group. This information is continually fed to the appropriate senior manager to ensure any operational issues		• Lack of resources/accurate and timely information and data • Lack of multi agency/partnership involvement • Systems and processes disjointed	• Continued expansion of membership adds to the intelligence provided to the partnership • Feedback from Cluster Profiles/Cluster Development plans help to inform possible projects/innovative solutions to improve

understanding of the profile and health needs of homeless people & vulnerable groups in their area.	can be addressed effectively. Currently the need for Access Cards that can be used by Vulnerable Groups has been flagged. This would be valuable to use across the ABMU footprint. There are plans to pilot this with the Penderi and City Networks as part of the Asylum Seeker Support Project. These cards can also be piloted with homeless groups and gypsy travellers via HHAVGAP. Information has been circulated to members of the HHAVGAP group on cultural awareness training. It is hoped that this information can inform future Protected Learning Time Sessions for GPs and front line staff and other key organisations. GP Cluster Networks continue to develop initiatives based on the population and wellbeing profiles of their networks and issues identified in Cluster profiles eg: Asylum Seeker Support/English for Health/Mental Health initiatives			services and access arrangements for Vulnerable Groups • Training to continue to be offered as appropriate to partner organisations to increase awareness of the needs of Vulnerable Groups

4. Access to Healthcare Homeless and vulnerable groups have equitable access to a full range of health and specialist services.	Key Actions noted for October 2017-March 2018 have continued during April 2018-September 2018. Case Studies continue to be presented at HHAVGAP meetings as a 'reality check' to determine where services are performing well and where improvements could be made. Any issues are fed back as appropriate. The HHAVGAP Group in Swansea has developed posters to promote language line. These posters have been shared with GP Practices across the City. As part of the English for Health Project Access Information is being developed for Speakers of Other Languages. EYST has received funding from the Integrated Care Fund to extend the Asylum Seeker Support Model to the Penderi Cluster Network in addition to the work being undertaken in the City Network. Ther Penderi Cluster Network also piloted a successful short		• Increase in demand • Access to interpretation and translation services • Issues raised are not prioritised/ undertaken owing to work/ delivery pressures	• Health Service for Homeless and Vulnerable Groups is delivered out of Orchard Street Clinic and Access Point. The service is offered on a flexible and outreach basis to suit the needs of the individual.

	term English for Health Project in May and June supporting Asylum Seekers with health related 'English' to help when accessing health services			
5. Homeless & Vulnerable Groups' Health Action Plan (HaVGHAP) The Health Board leads the development, implementation & monitoring of the HaVGHAP (as an element of the Single Integrated Plan & regional commissioning strategies) in partnership with the Local Authority, service users, third sector & other stakeholders.	The Local HHAVGAP Action Plan is in place and continues to be reviewed regularly by the HHAVGAP Group in Swansea. The current action plan was reviewed at the meetings held on June 13th and September 12th. It is a living document that changes following each meeting according to actions and current initiatives.		• Systems/processes not joined up • Lack of partnership/multi agency working	• Western Bay Housing Symposium to be held on October 5th will help inform best practice and discussions going forward. • Mental Health Event to be held on November 1st will inform mental health partnership discussions with specific reference to Vulnerable Groups. • Publication of Local Authority Homelessness Strategy will also further inform the Action Plan and developments moving forward

Please ensure that the update you provide considers all vulnerable groups. For gypsy and travellers, when providing an update, please consider the outcome measures as detailed in 'Travelling for Better Health' (this will ensure that a separate update is not commissioned).

- Travelling for Better Health is available at: http://gov.wales/docs/dhss/publications/150730measuresen.pdf EIA Practice Hub – NHS CEHR/WLGA 2015 – http://www.eiapractice.wales.nhs.uk/home
- The Essential Guide to the Public Sector Equality Duty: An Overview for Public Authorities in Wales (EHRC)

11. LIST OF ABBREVIATIONS

ABMU	Abertawe Bro Morgannwg University
AOS	Acute Oncology Service
CAMHS	Child and Adolescent Mental Health
CBC	County Borough Council
CNS	Clinical Nurse Specialist
COPD	Chronic Obstructive Pulmonary Disease
CRT	Community Resource Team
CT	Computerised Tomography
DEXA	Dual Energy X-Ray Absorptiometry
DNA	Did Not Attend
DU	Delivery Unit
ECHO	Emergency Care and Hospital Operations
ED	Emergency Department
ESD	Early Supported Discharge
ESR	Electronic Staff Record
eTOC	Electronic Transfer of Care
EU	European Union
FTE	Full Time Equivalent
FUNB	Follow Up Not Booked
GA	General Anaesthetic
GMC	General Medical Council
GMS	General Medical Services
HB	Health Board
HCA	Healthcare acquired
HCSW	Healthcare Support Worker
HYM	Hafan Y Mor
IBG	Investments and Benefits Group
ICOP	Integrated Care of Older People
IMTP	Integrated Medium term Plan
IPC	Infection Prevention and Control
IV	Intravenous
JCRF	Joint Clinical Research Facility
LA	Local Authority
M&S training	Mandatory and Statutory training
MIU	Minor Injuries Unit
MMR	Measles, Mumps and Rubella
MSK	Musculoskeletal
NDD	Neurodevelopmental disorder
NEWS	National Early Warning Score
NICE	National Institute of Clinical Excellence
NMB	Nursing Midwifery Board
NPTH	Neath Port Talbot Hospital
NUSC	Non Urgent Suspected Cancer
NWIS	NHS Wales Informatics Service

OD	Organisational Development
OH	Occupational Health
OPAS	Older Persons Assessment Service
OT	Occupational Therapy
PA	Physician Associate
PALS	Patient Advisory Liaison Service
P-CAMHS	Primary Child and Adolescent Mental Health
PCCS	Primary Care and Community Services
PDSA	Plan, Do, Study, Act
PEAS	Patient Experience and Advice Service
PHW	Public Health Wales
PMB	Post-Menopausal Bleeding
POVA	Protection of Vulnerable Adults
POWH	Princess of Wales Hospital
PTS	Patient Transport Service
Q&S	Quality and Safety
R&S	Recovery and Sustainability
RCA	Root Cause Analysis
RDC	Rapid Diagnostic Centre
RMO	Resident Medical Officer
RRAILS	Rapid Response to Acute Illness Learning Set
RRP	Recruitment Retention Premium
RTT	Referral to Treatment Time
SAFER	Senior review, All patients, Flow, Early discharge, Review
SARC	Sexual Abuse Referral Centre
SBAR	Situation, Background, Analysis, Recommendations
S-CAMHS	Specialist Child and Adolescent Mental Health
SDU	Service Delivery Unit
SI	Serious Incidents
SLA	Service Level Agreement
SLT	Speech and Language Therapy
SMART	Specific, Measurable, Agreed upon, Realistic, Time-based
StSP	Spot The Sick Patient
TAVI	Transcatheter aortic valve implantation
UDA	Unit of Dental Activity
UMR	Universal Mortality Review
USC	Urgent Suspected Cancer
WAST	Welsh Ambulance Service Trust
WFI	Welsh Fertility Institute
WG	Welsh Government
WHSSC	Welsh Heath Specialised Services Committee
WLI	Waiting List Initiative
WPAS	Welsh Patient Administration System